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For Children of Migrants

Mentally Retarded Teenagers

Influence of Breast-Feeding

Child Welfare in Ceylon

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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MIGRANT CHILDREN with their teacher in a day-care center in Pennsylvania. Caring for the children of agricultural migrants while their parents work has become an increasing concern of welfare departments in areas which depend on itinerant farm hands in the harvesting season. How a child welfare worker fitted into a coordinated program for migrants in 3 counties in North Carolina is described on pages 87–92.

ELEANOR CROCKER is at present with the Associated Day Care Services of Boston, giving casework to parents of children in day care and consultation to teaching staffs. In the summer of 1961, a year before she graduated from the Boston University School of Social Work, she studied the techniques of family group therapy and the principles of community mental health administration at the National Institute of Mental Health as a summer intern.

After earning a doctorate in clinical psychology from the University of California in 1958, MARTIN HEINSTEIN worked on a collaborative study of child behavior and cerebral palsy at the National Institutes of Health. Previously, he was research director at the child development center of the Children's Hospital of East Bay in Oakland, Calif. He is on the faculty of the San Francisco State College, where he teaches child development.

On leave from his present post, which he has had since 1955, JACK PARSONS spent the years 1958–60 with Ceylon's Department of Probation and Child Care Services, under the sponsorship of the Asia Foundation. He has in the past been superintendent of two children's institutions and has been on the social work faculty of the University of Pittsburgh. His Ph. D. is from the University of Chicago.

SIDNEY GERSHENSON (left) is at present working with the United Community Centers of San Francisco where he will become program director next January. MEYER SCHREIBER (right) directed a center for retired workers in Detroit before taking his present job 3 years ago. He is field instructor for the schools of social work of Hunter College and Fordham and New York Universities.

In addition to directing the clinic for retarded children, DR. J. WILLIAM OBERMAN conducts a program of diagnosis and treatment for preschool-age mentally retarded children in the child health clinics of the District of Columbia. He is also assistant clinical professor of pediatrics at the Georgetown University School of Medicine.

DR. NATHAN ACKERMAN directs the family mental health clinic at the Jewish Family Service, New York, as well as the Family Institute which he helped to found. A pioneer in family therapy, he described some of his theories in the July–August 1961 issue of CHILDREN. He is author of the book, "The Dynamics of Family Life."

◂ *the authors*

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How three North Carolina counties include the services of . . .

A CHILD WELFARE WORKER IN A PROGRAM FOR MIGRANTS

ELEANOR CARTWRIGHT CROCKER
Former Child Welfare Worker
Camden County (N.C.) Department of Public Welfare

EVERY SUMMER some 5,500 migrant farmworkers and their families come up from Florida, Georgia, and South Carolina to Camden, Currituck, and Pasquotank Counties in North Carolina to harvest potatoes, beans, and cucumbers. At season's peak some 3,800 migrant workers and their families are in these counties at the same time. Last summer they lived in 44 camps, 20 of which had received permits from the health department. These camps housed approximately 600 children under 16.

While for several years a variety of efforts had been made to meet many of the health, welfare, and educational needs of these families, and especially their children, these were not completely coordinated until 1962 when the Tri-County area was designated as a pilot demonstration project by the U.S. Department of Labor to see what could be done with a concentration of public and voluntary services to these migrants. How the services of a child welfare worker on the staff of the Camden County Department of Public Welfare fitted into the efforts of the Tri-County Citizen's Committee on Migratory Labor, formed to carry out this project, will be described in this article.

Based on a report from Camden County, N.C., to the North Carolina State Board of Public Welfare.

Since 1955, Camden County has been the location of a day-care center for migrant children operated in public school facilities by the Migrant Ministry of the Elizabeth City Ministerial Association and supported by the North Carolina Council of Churches. Over the same period of time, the Camden County Department of Public Welfare has each summer employed a child welfare worker to work with the migrants, her salary being paid by the State from Federal child welfare services funds. During the 1962 season, the child welfare worker divided her time between direct services to the children and parents of the camps as well as to the staff of the day-care center, and work with the local citizen's committee to bring about more positive attitudes toward the migrants.

Thirty-five children attended the day-care center regularly during the 6 weeks of its operation in 1962. Enrolled as a result of visits to the camp by the center's director, they were picked up five mornings a week by the center's 5 staff members in station wagons belonging to the local migrant ministry. At the center they were fed nourishing food, took naps, and played together, and the older ones learned simple craft skills.

The child welfare worker used the center as her headquarters, working out of there into the camps. She did this for two reasons: (1) because the day-care center was a kind of filter center for all the program's activities; and (2) because of the de-

cision to concentrate her attention on the families who had children in the center.

She was involved in the work of the day-care center in two ways: (1) direct work with the parents and staff to bring health and welfare services to the children; and (2) conferences with the center's staff to sharpen the teachers' awareness of the children's individual needs. In addition to casework with specific families in relation to special needs, her direct health and welfare activities included arranging with the local public health doctor and nurse for physical examination of the children, securing health records on the children from the parents, and helping the parents to follow up on the doctor's recommendations. She began by writing a letter to the parents who had children enrolled in the day-care center explaining the importance of health examinations and records. Then, accompanied by the center's director, or the liaison officer between the center and the committee, who already knew the parents, she visited each mother and read and explained the letter.

These first camp visits were the beginning of relationships not only with the parents who had children in the center but also with other parents and children encountered in the camps who needed medical or social work attention. They were followed in a few days by return visits during which the child welfare worker picked up the health records which had in the meantime been made out by the mothers, and distributed a 1-page directory of clinic schedules and information about her own services. The mothers turned in immunization records on more than half the day-care center's children, although only one mother had brought such a record with her to the camp. All the child welfare worker's visits to the camps were made with permission and sometimes the help of the crew leaders.

Participants at the farewell party for children given at the end of the 1962 season at the day-care center for the children of agricultural migrants in Camden County, N.C.

Although only 35 children came regularly to the day-care center, 44 received health examinations there since several mothers sent their children to the center just for this purpose. TB patch tests made on all these children were uniformly negative. Other physical defects were discovered, however, in 15 children, and the child welfare worker discussed with the mothers the possibilities of, and resources for, getting the defects corrected.

In weekly case conferences with the center's teachers the child welfare worker led discussions of the needs of specific children, each child having a turn as the focus of attention. These conferences were also used to discuss standards and suggestions for day-care centers issued by the North Carolina State Board of Public Welfare. The child welfare worker also participated in general staff meetings held at the center, conducted by the executive secretary of the citizen's committee and attended by the committee's liaison with the center, the Migrant Ministry's chaplain, the center's director and staff, and the county director of public welfare. At these meetings, ideas, feelings, and experiences were exchanged and additional plans made.

One of the season's most successful projects developed from such a general staff discussion. This was a Harvest Talent Show, conceived at first as a closing program for the children of the day-care center and their families. Since open house held for the parents had not proved successful in the past, it was thought that a program in which the children participated would be more likely to attract the parents. The original plans expanded to include talent from the various camps and local groups as well. Chief goals of the event were: (1) to help parents take pride in their children and their achievements, and to have fun with their children; and (2) to provide an opportunity for pleasant and purposeful interaction between the migrant community and local citizens.

The staff made floaters and posters which they distributed to the camps. In addition, the child welfare worker visited each crew leader to ask about talented persons in his group who might be interested in participating and also to ask for help in arranging

transportation—a problem in any program for migrants.

The event was an obvious success, although the people arrived at all hours—between 8 p.m., the hour set for the program to begin, and 11 p.m., when the last potato grader shut down that night and there was no more work to do—work necessarily comes first with migrant crews. In addition to the children's part of the program, the event consisted of four acts put on by local people and five by migrants. Prizes were awarded to the winning acts and refreshments served. The 75 people who attended seemed to enjoy themselves immensely, particularly the children.

Services to Individuals

The child welfare worker provided special individualized services to 26 families during the season. Of these "special welfare service cases," 2 involved referring mothers to well-baby clinics; 3, referring expectant mothers to prenatal clinics; 1, helping a family to make appropriate arrangements following the death of an infant; 2, referring sick children to private physicians; 4, providing casework services to emotionally upset adults; and 10 involved certifying families for U.S. Department of Agriculture surplus foods. These last were families who remained in the area after the harvesting season closed because they could not find work elsewhere. During her visits to these families, the child welfare worker distributed magazines and health kits and organized games for the children.

An emergency fund of $25, created by a private donor, was used by the child welfare worker for making small individual loans. This proved especially helpful when medical attention or medicine was needed quickly. In at least two instances loans for medicine saved the borrowers from hospitalization and the county a medical bill.

The following examples illustrate some of the directions in which the child welfare worker provided casework help.

Corinna, a teenage girl, was referred by a crew leader's wife when the worker visited a camp to secure vaccination records. She had been "acting crazy" since the weekend, running up and down or withdrawing and talking with no one. She was alone on the crew, and although some of the people knew her home town, no one knew her address. By following a clue on a medicine bottle in the girl's possession, the child welfare worker learned that the girl was an epileptic. Appropriate medication, prescribed by the county health officer, was secured for her by using money from the emergency fund. Eventually the girl was able to give her mother's name and address. She then gave the child welfare worker permission to write her mother and ask for aid in returning home. Soon afterward, the mother arrived from Florida to get her daughter, saying that the girl had run away from home and that she had been "worried sick" about her.

* * *

A pregnant woman, separated from her husband, had arrived at the camp with three preschool children, one of whom had severe asthma, and two, pinworms. She said she had come with the group because her sister was the crew leader's wife and because she was not making enough money in Florida to feed her family and keep the children at a day-care center while she worked. In a series of interviews with the child welfare worker, she focused mainly on her great fear of childbirth, which derived from her knowledge that she had a heart condition and from the fact that she had spent $45 on abortatives and was now afraid that the expected child would be a "tadpole or worse."

Because this woman had read many popular articles on illness and disease, the child welfare worker gave her articles and pamphlets about pregnancy and birth, as well as material on child rearing which they discussed together. She made arrangements for the woman to visit the prenatal clinic and for her children to see the doctor at the day-care center and tried to help her both accept and prepare for the new baby by encouraging her to begin a layette from used clothing available at the center. The child welfare worker also discussed with this mother the possibility of taking steps to secure support payments from her husband upon her return to Florida.

* * *

Miss W and her diabetic son were referred to the child welfare worker by the health department. The child had just been taken to the hospital as a result of not receiving his appropriate insulin dosage. Miss W and her three illegitimate children had come along on the crew with Miss W's mother. She had never traveled before because of her son's disability and had not taken into account the change in diet and exercise while traveling. She seemed to be a very dedicated mother who made every effort possible to regulate her son's diet as the doctor prescribed.

In Florida the family had been on the ADC rolls and had received insulin from the county. Miss W was very much upset to find that she could not do the same everywhere. She had just arrived, had not worked, and therefore had no money. The child welfare worker lent her money for a week's supply of insulin from the emergency fund, asking that the money be paid back so that others in need could be helped. With this medication, the boy's dosage was readjusted and he was released from the hospital. Shortly thereafter, Miss W decided that she had better move on to New York or return to Florida as quickly as possible in order to be surer of getting insulin for her son.

Community Interaction

One of the chief goals of the Citizen's Committee on Migratory Labor was to foster positive attitudes toward the migrants on the part of the local citizenry. The child welfare worker had lived in the Tri-County area most of her life and thus was familiar with local feelings toward the migrants, the majority of whom were Negroes of economically and educationally deprived backgrounds. Since the prevailing reaction to them among the local people seemed to be fear, she worked consciously to bring about a more widespread realization that the depredations of a few persons who did not know how to take care of the facilities provided them did not mean that all migrants were characteristically wanton persons. Thus she helped the committee to create new opportunities and seized every chance

opportunity offered to increase favorable interaction between the migrant community and the local people.

The Tri-County Citizen's Committee on Migratory Labor (now the Albemarle Council on Migratory Labor) was composed of local citizens and professionals who served on seven subcommittees: executive; health and welfare; finance; volunteer social service; recreation; audiovisual materials; and public relations. The child welfare worker served on four of these and became involved in some way with all of them. She also served as secretary of the executive committee, and of the health and welfare committee.

Health and Welfare Committee

In working with the health and welfare committee the child welfare worker was particularly active in three of the committee's projects:

1. ***The sponsoring of awards for the crew, crew leader, and grower whose campsite was kept in the cleanest and safest condition.***

The purpose of these awards was to encourage the crews to take better care of the grower's property and thus foster better relationships between owner and workers. The public health sanitarians and agricultural extension agents in each county prepared a score sheet, and visited 31 camps in the 3 counties in order to rate them.

The child welfare worker helped make arrangements with the growers for the prizes and presentations. She and the employment security interviewer from the U.S. Department of Labor visited each crew leader in Camden County, gave them material, discussed the purpose of the awards, and told them when the inspection team would visit their camp. Crew leaders in the other two counties were notified through the Employment Security Commission. After the scores were tallied, presentation ceremonies were held in all the counties. The winning crews were given watermelons, and the crew leader, grower, and all second place winners were given certificates. The growers seemed pleased with the project and asked that it be repeated the following year.

2. ***The establishment of a first-aid course.***

The Red Cross representative on the health and welfare committee stated early in the summer that volunteer instructors were willing to conduct first-aid courses in the camps if the child welfare worker would make the necessary arrangements. One of the difficulties was finding a time when both migrants and instructor could get together. The child welfare worker surveyed one of the camps and found 16 young people who said they would be interested in taking the course. With the permission of the crew leader, she and a Red Cross instructor visited the camp together one lunch time and met with this group. It was decided to hold the classes on Sunday morning. Twenty-one persons attended the first meeting. However, the instructor, who had never visited a migrant camp before, was so impressed with the interest and background of the group that he switched from a junior to a senior course, and as a result half the class dropped out. Nevertheless, seven persons completed the course and were awarded Senior Red Cross first-aid certificates. The local Red Cross Chapter lent the project books so that the students could study between sessions.

Plans are underway to increase the number of classes for migrants in 1963 and to introduce courses in maternal and child care.

3. ***The operation of a clothing store.***

In line with its policy of helping the migrants help themselves, the health and welfare committee decided to open a used clothing store rather than to distribute clothes free. The store was located in the day-care center and did its most active business on Saturday night when a recreation program for teenagers and adults was also held in the center. Both the child welfare worker and center staff helped run the store but the bulk of the work was done by the members of a local Negro woman's club. The club members were on hand each Saturday night, helped with the sales, played with children while the mothers shopped, and totaled bills.

Approximately $60 was collected from clothing sales. The clothing receipts went back into the program to help buy recreation equipment, and the migrants were informed of this by the saleswomen and through posters.

The clothing store provided an excellent opportunity for the child welfare worker to meet and further relationships with individual migrants. Family plans and concerns were easily discussed as she helped a mother look for clothing. This was especially true in respect to pregnant women who were looking for layette pieces. It was easy to go from a discussion of an infant's clothing needs to a consideration of related necessities—sterilized bottles, diaper changes, immunization shots. Two referrals to prenatal clinics were made in this way.

A fourth project of the health and welfare committee did not get off the ground last year, but groundwork was laid for carrying it forward this year. After the season was already underway, plans

were initiated to employ a homemaker to work with the migrants with funds available from the State Board of Public Welfare. The child welfare worker talked in several camps about the uses of a homemaker and also interviewed three applicants for the position. However, it was finally decided that because the season was so far advanced, it would be best to postpone the program for another year. The public welfare boards of the three counties have approved the position and several applicants have already taken the merit examination. Plans are to use the homemakers for both education and service.

Recreation Committee

A successful part of the migrant project was the weekend recreation program provided at the day-care center by two committees—one on audiovisuals, which arranged for Saturday night movies, and one on recreation, which sponsored Sunday afternoon athletics. The committee on audiovisuals was headed by a professor at the State Teachers College, who arranged for his students to get field-work credit for helping to run the movies. The chairman of the recreation committee, a local businessman, provided equipment free for the athletic program.

The chief difficulty faced in the weekend recreation program was the same encountered by any phase of work with migrants—setting a time at which most of the migrants would be free. Many migrants work until late Saturday afternoon and then must do their grocery shopping or washing at the laundromat. Transportation was also a problem. Nevertheless, about 25 persons usually attended the movie, many of them attracted by the clothing sale, and 60 to 75 persons usually participated in the athletic program, most of them teenagers.

In connection with these programs, the child welfare worker personally contacted crew leaders in the various camps, enlisting their help in putting up posters and distributing fliers announcing the programs. On Saturday night she helped with the clothing sales, played quiet games with the children, and visited with the people who came, using the opportunity these activities provided to find out more about their needs. On Sunday afternoons she organized games for the younger children, such as croquet, horseshoes, and dodge ball.

The recreation chairman received considerable criticism from some local citizens for his participation in the program, which seemed to add to his determination to demonstrate that the migrants could take advantage of and enjoy an athletic program. And they did. There was not a single unpleasant incident during the entire season. Plans for this summer are to try to draw more adults into participation in the program.

Public Relations

The child welfare worker worked closely with the editor of the local paper, who was chairman of the public relations committee, in efforts to get news coverage for all special events involving the migrants. She also wrote a feature article for the paper on the role of social work within the program.

The project also received considerably favorable publicity through other channels, much of it due to the interest of one reporter for an out-of-State paper read widely in the area. His series of four feature articles, with pictures, introduced many local people to the idea of the migrants as people with normal human needs and ambitions. One response to this was a check for $150 and a moving van filled with clothing, toys, and health kits sent to the day-care center by a group of women from nearby Suffolk, Va. An article in the *Raleigh News and Observer* also brought some response in cash as well as many encouraging letters.

The local radio station also participated in publicizing various aspects of the migrant program through spot announcements on the needs of and facts about the migrant population.

In all these efforts problems of the growers and the community as well as of the migrants were presented.

As to the Future

As a result of her experiences with the migrant program in 1962, the child welfare worker made a number of recommendations for the future.

To the future child welfare worker:

1. Attend pre-season meetings with growers and with crew leaders to become acquainted with them and make herself and her role known.

2. Make at least two early visits to the migrant camps, planned for in advance with the Employment Security Interviewers of the Labor Department, to become acquainted with the crew leader and his wife and other indigenous leaders.

3. Help the day-care center director in enrolling children by visiting camps and talking with mothers, gathering health information on the children in the process.

4. Prepare a directory of health and welfare resources for crew leaders and workers.

5. Help the homemaker, if one is available, plan and carry out needed services.

6. Work from the day-care center back to the camp.

7. Be aware of cultural influences as well as personality factors in dealing with individual migrants.

8. Keep a flexible time schedule!

The child welfare worker found that many attitudes, traits, and problems she encountered in working with the migrants were closely linked to the culture of the group. For example, the migrants who come to these three North Carolina counties are apt to be impulsive and to operate on a completely different time dimension than the local citizen. They are slow to trust the outsider, and communicate with difficulty, frequently echoing affirmatives and nodding in understanding, when they in fact have not grasped the impact of what has been said.

The importance of flexibility in time schedules in dealing with the migrants derives from the facts that they must work every possible minute they can, adjusting their working hours to the grower's needs, and do their shopping whenever the crew leader provides transportation to town. Thus it is sometimes necessary to visit families in the fields or go to the camps on rainy days when most of the migrants are apt to be there.

To the health and welfare committee:

1. Find a way of providing a mobile health unit to make the round of the camps soon after the migrants arrive.

2. Encourage the counties to follow through on the plans to make homemakers available to migrants in each of the three counties.

3. Increase the emergency fund by requesting $25 per county from the citizen's committee.

4. Utilize the services of the home agents of the Agricultural Extension Service, who have indicated their willingness to give home improvement and charm courses to the migrant women.

5. Encourage the subcommittee on house and grounds awards to meet with the growers in early spring to enlist their support for the program.

To the recreation committee:

1. Continue the weekend recreation program in 1963.

2. Enlist the cooperation of crew leaders to provide transportation to the center on weekends.

3. Begin the Saturday night program with a clothing sale before the movie and provide activities for the children while the parents shop.

4. Make greater efforts to involve adults in the Sunday afternoon program.

5. Request the Elizabeth City State Teachers College to continue its program of field-work assignments for their students in the program, and make efforts to secure other volunteers as well.

6. Hold the Harvest Talent Festival on Sunday afternoon and make the "house and grounds" awards during this event.

Conclusion

The organization of the citizen's committee for the Tri-County area has combined what were more or less individual efforts into a collaborative effort by agencies, growers, professionals, and citizen volunteers to help the migrants meet their basic human needs better and in doing so to help them to become more respected citizens. The importance of what this had accomplished so far is not diminished by the fact that many migrant problems remain. Their solution calls for legislation, particularly the enactment of measures to require crew leader registration and to provide social security coverage and health and accident insurance for migrant workers and funds for short-term education projects.

The author, who was the child welfare worker whose activities are described in this article, believes that one of the major accomplishments of the 1962 program was the beginning of a changing attitude on the part of local citizens toward the migrants. This was evidenced by their response to the program and by the growers' gradual acceptance of the citizen's committee and its purpose. While only a few growers were actively involved in the program, the strong negative feelings toward the migrants often expressed by growers in the past seemed to be absent. This change was undoubtedly helped by efforts of the citizen's committee to consider the grower's interests as well as to help him see the migrant as a person with capacity and abilities which can be developed if given a chance.

A study relating mothers' attitudes and length of nursing to the . . .

INFLUENCE OF BREAST FEEDING ON CHILDREN'S BEHAVIOR

MARTIN I. HEINSTEIN

Research Psychologist, Child Health Research Unit
California State Department of Public Health

BREAST FEEDING has at times been singled out as the royal road to successful mothering and mental health for the child. Freud, through his concept of orality, made the nursing experience of the infant a central issue in the study of personality. His clinical findings and speculations about oral gratification and deprivation have received a great deal of attention in the literature about child development.

Nevertheless, the effects of various nursing regimes on a child's physical and emotional development are still essentially unknown. Equally obscure are the influences which induce a mother to feed her child from the breast. Few facts have been established despite speculation dating back to Hippocrates and a considerable amount of recent research.

A decline in the proportion of mothers in this country who breast feed has been apparent over the past several decades, although significant geographic differences have been noted in the frequency of the practice.[1-3] Research carried on in the 1930's and 1940's showed mothers from lower socioeconomic groups undertaking breast feeding more frequently and weaning their children later than mothers with higher socioeconomic status. Some recent studies indicate that these differences may now no longer exist or may even have been reversed.[4, 5]

Much of the research about the influence of breast feeding on child development has suffered from some obvious defects. None of the studies have attempted to evaluate the personality of the mother doing the the feeding as well as the type of feeding being done. Nor have the studies taken into account the possibility that a tense, breast-feeding mother may present a more disturbing environment for an infant than a relatively relaxed, bottle-feeding mother. Furthermore, few, if any, studies have looked for possible differences in reactions on the part of male and female children, or to possible variability of response with the age of the child. Behavior disturbances apparent at the time of weaning may not be present at subsequent stages of development.

Studies have usually relied too heavily on retrospective data. Reports from mothers several years later on how they fed their babies and their children's later reactions are likely to be unreliable. Moreover, investigators have usually studied only special groups, such as middle-class families or children being treated at a clinic. Few studies have used samples representative enough of the general population to permit broad deductions.

The study to be reported upon here made use of longitudinal data collected on a representative sample of children—a sub-sample of every third child

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Based on a monograph to be published by the Society for Research in Child Development. This monograph will contain the supporting data on which the findings of the study reported in this article are based.

born in Berkeley, Calif., from January 1, 1928, to June 30, 1929. The data covered a period from the birth of the child to 18 years of age. Behavior problems of the children during the preschool period, middle childhood, and adolescence were looked at in relation to whether or not the children were breast fed, the length of their nursing experience (whether from breast or bottle, or both), and the family atmosphere during the nursing period.

The term *nursing* will be used in this article, as it was in the study, to refer to the period of breast and bottle feeding, or both. *Length of nursing* was determined by fixing the time at which the child was weaned to the cup.

The 47 boys and 47 girls in the sample had been studied intensively for physical, mental, and personality development by the Institute of Human Development at the University of California, Berkeley. Data were also available on the general characteristics of the parents, the mother's relations to the child, and the socioeconomic status of the family. Testing and intensive, open-ended interviews had been conducted periodically over the 18-year period. The sample and program of data collection have been described in previous publications.[6]

Study Variables

The main variables considered in this study were: (1) breast feeding without supplementary nursing; (2) length of nursing; (3) the warmth of the mother toward the child; (4) the nervous stability of the mother; (5) the marital adjustment of the parents; (6) and the behavior problems of the child. The warmth of the mother was determined by a combined average rating of the mother's closeness to the child, general friendliness, and expressiveness of affection toward her child.

The behavior of the child was evaluated both from reports of the mother, starting when the child was 21 months old, and interviews with the child starting when he was 6 years old. Ratings on behavior problems such as temper tantrums, thumb-sucking, fears, and enuresis were used for the preschool period and middle childhood. The results of projective testing by the Thematic Apperception and Rorschach tests were the basis for behavior assessment in late childhood and adolescence. Ratings of the personalities of the parents, their relations to each other and to their children were based on the reports of the intensive interviews.

While no other studies to date have looked into the joint influence of the mother's personality and the nursing process on the child's behavior, a number have focused on the characteristics of mothers who did and of those who did not breast feed. Some of these studies have been based in part on the supposition that the mother's personality and her feelings toward the child are related to her decision to breast feed or not. For example, Levy at one time maintained that weaning was an index of maternal rejection.[7]

On the other hand, two studies [8, 9] reported 16 years apart found no evidence that breast feeding was related to whether the mother wanted the child or to the degree of warmth of the mother toward the child. One of them, however, indicated "that breast feeding probably does have some special implications for quite a good many mothers, and that those who have a strong sense of modesty or anxiety about sex, in general, may avoid breast feeding."[9] Another study found that the "biologic type" of mother prefers to breast feed and to avoid a rigid schedule, while the "modern urban type" tends to bottle feed on a rigid schedule.[10]

In the present study, none of the variables used to define the mother-child relations or the general family atmosphere was found to be significantly related to breast feeding. For example, factors such as the warmth of the mother toward the child or the marital adjustment of the parents were not associated with breast feeding or with the duration of breast feeding. Thus the data can hardly be interpreted as representing evidence that breast feeding is a reliable measure of maternal acceptance of the child.

The socioeconomic status of the family, however, was associated with the duration of breast feeding. For both boys and girls, the lower the socioeconomic status of the family, the older the age of the child at weaning from the breast.

The relationship of lower socioeconomic status with longer duration of breast feeding is consistent with the results of other studies using breast-feeding data from about the same period (1928–29). As already mentioned, more recent investigations tend to indicate no differences in this respect between social classes while some studies report longer or more breast feeding by middle-class mothers. Possibly the recent rise in the proportion of mothers from lower socioeconomic groups who are working outside the home has decreased the opportunity for breast feeding among them. At the same time, the emphasis in pediatric and child development publications on the psychological benefits of breast feed-

ing for the child has probably been influential in fostering positive attitudes toward breast feeding among middle-class mothers. The relatively greater decline of breast feeding among mothers of the lower socioeconomic levels may also mean, at least in part, that these mothers have reached standards of child care followed by middle-class mothers several decades ago.

Health and Behavior Problems

The study gave no evidence of breast feeding being positively related to favorable growth or general health of the child. On the contrary, length of breast feeding for both boys and girls correlated negatively with the rate at which the children reached various heights—one index of maturation. Four of six overall health ratings also correlated negatively with breast feeding. The health ratings were based on periodic physical examinations and frequency of illness. The study was not designed, however, to answer specific questions about the relation of breast feeding to health.

The study also failed to reveal significant differences in incidence of problem behavior between breast-fed or bottle-fed children—whether boys or girls. The findings of previous studies are noticeably inconsistent in this respect. In four studies, children who had been breast fed for 4 to 10 months were better adjusted than children who had been breast fed shorter or longer periods. Three studies reported that the later the weaning from the breast the fewer the behavior problems. Two other studies, in direct contrast to the first four mentioned, indicated that the best adjustment was among subjects breast fed for very short periods or not at all, or for a long period (11 or 12 months). Four other investigations found no significant differences in behavior according to the length of breast feeding.[11]

Parental Factors and Nursing

Psychologists who are influenced by learning theory and psychiatrists who place more emphasis on interpersonal transactions than on libidinal drives have regarded the personal-social environment of the child as fundamentally more important than a particular nursing regime. They have maintained that positive, early relationships of the child with the parents, particularly the mother, are likely to carry over to other later interpersonal relations.

The results of this study revealed that in general the daughters of the more stable or of the warm mothers had fewer behavior problems. For boys, only the warmth of the mother was associated in any degree with positive behavior. The marital adjustment of the parents showed no noticeable association with the behavior of either boys or girls when this factor alone was considered in relation to behavior problems.

Findings based on such single factors in the child's environment as the warmth of the mother, her nervous stability, or the marital adjustment of the parents were not as pronounced as the associations apparent when both the parental characteristics and the nursing situation were considered at the same time. In fact, the results of this study seem to indicate that the interaction of the nursing and parental factors are more important for the adjustment of the child than either the nursing situation or parental characteristics taken separately.

While the nursing situation by itself did not seem to relate significantly to later behavior, it became a variable of importance when considered in connection with parental attributes, the sex of the child, and differences between the experience of breast feeding and length of nursing as such.

The most pronounced maladjustment shown in any group in the study was among boys who were nursed (on breast or bottle) for a long period of time (15 months or longer) by a *cold* mother (distant, hostile, inexpressive of affection). Length of nursing when considered apart from the personal characteristics of the mother doing the nursing, was not associated with any noticeable behavioral disturbances. Furthermore, boys who were nursed for a long period of time by a *warm* mother tended to be relatively free from behavioral difficulties. What became evident was the effects of experiencing *both* long nursing and a cold mother at the same time.

Extended nursing in our culture may be regarded as a sign of continuing dependency needs on the part of the child. The mother who accepts or fosters these dependency needs, but at the same time has feelings of rejection toward the child, is obviously ambivalent and providing an atmosphere of conflict for the child. Such a mother is perhaps not truly nurturant, but may use the dependence of the child as a basis for maintaining hostile control.

Dependence in the first years of life is not likely to be maladaptive if it is expressed and met within the context of genuine feelings of nurturance on the part of the mother. The boys in this sample who were long-nursed by a cold mother were, in effect, experiencing oversolicitousness and hostility at the same time. Too much from a mother who in reality

is able to give only too little is likely to result in confusion for the child.

Long nursing (weaned from the breast or bottle at 16 months or later) as such showed no significant overall association with behavior problems for girls, as it did for boys. However, when the results of the interaction between length of nursing and the maternal nervous stability were considered, girls who had a relatively unstable mother had fewer behavior problems when they were nursed for a long period of time. A shorter total nursing period was the most favorable duration when the mother was more stable.

Possibly mothers unable to provide a generally stable atmosphere for their daughters are able to compensate by added solicitousness in the nursing area. The capacity of the girl to benefit from a longer period of nurturance through nursing may reflect cultural differences in our demands for independence from boys and girls. Girls may be able to receive reinforcement of dependency needs longer than boys without being subjected to conflicting expectations that they become more independent and aggressive. This, of course, is clearly speculative. Apparently, however, boys and girls experience length of nursing in different ways depending, in part, on variations in personal-social environment.

Breast Feeding and the Mother

What about the effects of breast feeding generally when considered along with the feelings of the mother doing the feeding? For boys, breast feeding did not appear to be significantly related to problem behavior even when considered in the context of mother-child relations at the time of nursing. Whether the mother was warm or cold in her feelings toward her son was not associated with noticeably different kinds of behavior. In other words, the interaction of breast feeding and the warmth of the mother was not significant except when length of nursing was taken into account.

Girls, however, developed fewer behavioral difficulties if breast fed by a warm mother. However, those whose mothers were distant, unfriendly, and inexpressive of affection did better if bottle fed.

It is not unreasonable to suppose that the mother who breast feeds her daughter without real warmth provides an ambivalent and potentially more disturbing environment for her—a situation similar to the one experienced by boys fed by a long nursing, cold mother. The close, intense relationship between mother and daughter implied in breast feeding apparently should be part of a more generally warm mother-child relationship in order to effect lasting psychological benefits for the child. Where technical nurturance represents only a formal expression of love or when it occurs with feelings of rejection, the resulting confusion for the child again appears to be associated with behavior problems.

Why boys were unfavorably affected by the *long-nursing* situation with a cold mother and girls by *breast feeding* with a cold mother is not readily apparent. The ambivalence present in both of these general conditions, however, is clear.

The fact that behavioral difficulties seem to be generated by the long nursing-cold mother experience of the boys in this study and the breast feeding-cold mother situation of the girls has some relevance for the "double bind" theory of Bateson and associates.[12] It also has implications for Harlow's [13] findings on the importance of cuddling.

The main ingredients of the double bind, as described by Bateson, consist of two or more people in a repeated experience from which one, the victim, has no escape. The victim receives a primary negative (or positive) injunction which is in conflict with a more abstract secondary injunction. Thus the boys in this study who experienced a long nursing period with a cold mother were caught in a relationship in which the mother was expressing two orders of message, one of which denied the other. Technically, the long nursing or the breast feeding expressed a formal manifestation of nurturance or love, which was contradicted by a communication of the mother's feelings of hostility and lack of closeness.

Harlow's early work suggests the possibility that the amount and kind of cuddling the infant receives are more important psychologically than the nursing experience. While some of the evidence from the study described here indicated that the warmth and nervous stability of the mother as single factors in the child's early experience were more important than the nursing situation, the pattern of both factors together, nursing and the mother's personality, seemed to be the most decisive influence.

Implications of the Study

The results of this study point to the dangers of making oversimplified recommendations in relation to specific child-rearing procedures without consideration of the family atmosphere in which these procedures are to take place. Breast feeding or long nursing are not efficacious *per se*. In each instance, we must ask who the nursing mother is and what

the other relevant factors in the home environment are which impinge on the nursing experience of the child.

Further evidence supporting these observations may be gained from the study's findings in relation to thumb-sucking. Freud used thumb-sucking as a model for explaining the erogenous nature of the oral zone. As a result thumb-sucking has become a diagnostic sign for insufficient sucking satisfaction, disturbed emotional development, troubled mother-child relations, and a host of other ills. Levy, for example, has stated that the main cause of finger sucking is insufficient sucking at the breast or bottle.[14]

The greatest incidence of thumb-sucking in this study occurred among girls who were breast fed by mothers who had achieved a good marital adjustment and who were also judged better than average in regard to nervous stability. Not only are the results the reverse of what would be theoretically expected, but, again, the interaction of two factors, the breast feeding and the parental characteristics, was more significant than the effects of either variable considered separately.

Moreover, the results in this study and in two additional investigations based on large, representative samples of children, thumb-sucking was negatively correlated with other behavior problems in the preschool period. The thumb-sucking girl tended to come from a breast-feeding, stable environment, and girls and boys who as preschoolers sucked their thumbs were less likely than others to have other behavior problems.

Perhaps the most important conclusions of this study relate to the several methodological considerations raised in the early part of this article. Apparently sex differences *are* an important factor in evaluating the behavioral correlates of the nursing experience. Also, the pattern of the child's nursing experience within the context of varying personal-social conditions seems to provide a more decisive view of the child's emotional adjustment than do single factors, be they the nursing experience or particular characteristics of the parents.

The zeal of some people in trying to foster breast feeding or a particular child-rearing technique may derive from an oversimplified interpretation of psychoanalytic theory or a long held idyllic picture of mother-infant oneness. It is perhaps wiser without more definitive knowledge to view nursing as one aspect of the total life space of the infant or child. While the results of this study must also be viewed with caution, they do seem clear enough to raise serious doubts about some of the current *ex cathedra* pronouncements which appear on the topic of breast feeding or baby nursing in general.

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In distinction to the original sin that is believed to be part of man's inheritance, some original goodness must also be recognized. With all the evil and cruelty and injustice that exist in the world, there are still "reservoirs of compassion" in mankind that have scarcely been touched.

From an editorial in* The New England Journal of Medicine, *November 1, 1962.

An experience in Ceylon provides some principles for consultation on . . .

CHILD WELFARE IN A DEVELOPING COUNTRY

JACK R. PARSONS
Associate Professor, School of Social Work
University of Washington, Seattle

DETERMINING THE PACE at which to proceed is one of the most important decisions that a technical consultant to a developing country has to make. While rising expectations are everywhere apparent, the advances made with respect to children's welfare are too often of a pedestrian nature. This is true in spite of the expressed desires in some developing countries to "catch up" with other nations in child welfare achievements through embarking on crash programs. Counteracting these expressions, however, are others against any change, or warnings against moving ahead at any perceptible rate of speed.

A closely related problem facing the consultant in a foreign culture is determining his role: Does he follow in the "wake of social change," concentrating on helping people adjust to new situations? Or is he the transmitter of fresh values, the symbol about which the expectation of change revolves? [1] While definitive, final answers to these questions may not be possible, their solutions may in part lie in a variety of factors, including the stage of development of the country, the resources available, and the experience of those who are there on foreign assignments.

As a technical assistant in child welfare for 2 years in Ceylon, the author of this article faced both these problems.

In its organization of social welfare services, Ceylon presents a rather complex picture of public and voluntary services. The Department of Probation and Child Care Services, the major child-caring agency, was established in 1956, about 8 years after Ceylon achieved its independence from Great Britain. The original cadre of probation officers was at that time transferred from the Department of Prisons and has since been assuming child welfare duties in gradual stages. The Department of Probation and Child Care Services offers service throughout the island through 115 field service officers who are grouped under 7 districts, each district being administered by a chief probation and child care officer. The field service officers make social reports to courts in regard to children and adults brought before these courts, supervise persons released on probation or on court supervision orders, act on adoption inquiries, supervise children released from certified schools (public training schools for delinquents) and approved schools (private training schools), and provide protective services to deprived or abandoned children.

The Department also has responsibility for licensing and inspecting voluntary institutions as well as for administering grants-in-aid to about 115 voluntary institutions that are caring for dependent, neglected, and abandoned children. It also administers six certified schools, all for boys, three detention homes and three receiving homes. Other certified schools, including one for girls, are in the process of being established.

The Department of Social Services, another public agency, administers public assistance and a beginning social insurance program, as well as grants to agencies operating crèches, to schools for deaf and blind children, and to a few children's institutions.

Voluntary institutions represent the major resources for the care of children away from their own homes in Ceylon today. They are much older

than the public services for children, the oldest having been established over a century ago, and grew out of residential school programs established by various missionary groups.

Sponsorship of the institutions has been primarily by religious bodies, with the Roman Catholic Church having nearly two-thirds of the total children under care, the Protestant denominations having about 15 percent, and the Buddhist and Hindu religions each having about 10 percent of the children. In a culture which is predominantly Buddhist, the above distribution and sponsorship is not looked upon with favor. The Buddhist lay groups are attempting to change these proportions with all possible speed.

While most institutions for dependent and neglected children are combined with educational programs, some offer only residential care. A few institutions are specialized: for children with physical handicaps; for the mentally retarded; for young convalescents; or for blind and deaf children.

In 1960 public grants-in-aid were paid with respect to some 5,000 children under care in voluntary institutions. Approximately 7,000 children in all were estimated to be in institutions, or .2 percent of the child population under 19 years of age. Two-thirds of them were girls, possibly a reflection of the greater protection given females in the Ceylonese culture. Half of all children in the institutions were between the ages of 9 and 16 years. Approximately 8 percent were under 5 years of age and almost 3 percent were under 1. While the average age at admission was 7½, about 12 percent of the total had been admitted before they were a year old.

A Broadened Function

The 2-year project in which this consultant was engaged was originally perceived as a research task directed toward helping the Department of Probation and Child Care Services to learn more about the boys sent to its certified schools, so that better commitment policies could be effected and better treatment programs offered, and to devise some measures for gauging the effectiveness of the institutional program. Plans also called for the establishment of a permanent research office to serve the Department.

Upon arrival, the consultant was asked to assist in the training of the Department's staff as well as with the research. Such a switch in assignment is not unusual in the experience of foreign consultants for definitions of the job for which they were recruited often do not fit the needs of the country, usually because changes have taken place before or shortly after the consultant's arrival. This writer's decision to accept the request to serve as both research and training consultant was based upon several considerations: (1) the institutions were still in the construction stage, with the major work being done by the boys themselves, and any study of the program then prevailing in them would not have been typical of the programs that would be established once the housing, schools, and shops were completed; (2) the inclusion of training with research allowed for closer coordination between the institutional staff and the Department's field staff so that continuous responsibility for planning for each institutionalized boy could be achieved.

Use of Resources

The Department's two assistant commissioners, one in charge of field staff, the other in charge of institutional workers, took the major responsibility for organizing and conducting all research and training efforts, with the consultant playing a variety of roles. While the training aspects of the project occupied the greatest amount of the consultant's time, he also provided consultation on small studies on aspects of the institutional program.

The consultant very early became aware of a general lack of knowledge in the Department about existing resources. There had never been gathered together in a form the workers could use any file or list of the multitudinous social, health, recreational, and educational agencies in the country. Here the project's combination of research and training had some immediate values, for it set the stage for preparing the first nationwide directory, with over 3,000 entries. This was accomplished with the help of every field officer and chief probation officer and through the assignment of a senior officer to the research office to edit and arrange the material.

From the inception of the Department, the need for an orientation and training program for newly recruited officers had been recognized. In addition to a course for beginning workers, the Department had been holding an annual refresher course of 3 or 4 days for all field staff and institutional workers. Upon these beginnings the new training program was built.

One of the major problems that had to be faced was where to get the personnel to assist in the training programs. While the consultant could and did serve in a teaching, advising, and planning capacity, there was a question of how any contribution made in this way could be of lasting value.

In the discussions which sought to plan for a more complete and ongoing staff development program, the existing resources and potential resources were reviewed. One suggestion was to make better use of existing staff with special training or experience. The Department's two psychiatrists, the chief probation and child care officers who had each received 6 months of training in the United Kingdom, and the senior officers who had demonstrated a high quality of work were drawn into the training program.

Although the psychiatrists had been employed to provide treatment, their talents had been used occasionally for teaching staff and they readily acquiesced in a plan that would take more of their time for staff training with special focus on human growth and behavior. Later on, under their own plan, they began to serve the district offices as consultants.

The use of the chief probation and child care officers in a training capacity not only furthered the work of the Department directly but also helped these officials recognize more fully that they had a responsibility for teaching as well as administration. While some did better at teaching than others, in the main their training contribution was good. Furthermore, these experiences helped them to use part of their quarterly field staff meetings for case discussions, rather than as heretofore for purely administrative matters.

Training Programs

In the training plan, the senior officers were regarded as the potential supervisory staff for new trainees after they themselves had completed a more formal course of training. Plans were developed to send them away for additional training, but meanwhile short courses in supervisory methods were presented in an effort to provide a structured field training period. While this arrangement was something of a makeshift, alternatives were lacking.

To develop case material for teaching purposes, the familiar device of requesting submission of "successful" case examples was used. Cases were particularly requested from senior officers whose work was considered outstanding by their superiors. Other cases were found through sampling procedures and through the consultant's visits to local offices. When cases were found which illustrated the principles of social work that were to be presented in the teaching, they were carefully edited and pertinent excerpts extracted. These local cases proved to be far more acceptable to the workers than cases based on experiences in other cultures. The techniques of selecting and editing cases for training were also taught.

The question of whether social workers in another culture can or should accept American social work principles is frequently raised. The consultant found for the most part a ready acceptance of these principles in the Buddhist society of Ceylon. For example, acceptance of the principle of confidentiality was illustrated by a simple incident reported during an area staff conference. One worker described the villagers' habit of following him to a client's home with the expectation of listening to the interview. The worker was asked what he did when confronted with this situation. He replied that he politely but firmly asked the bystanders to leave, to which they acquiesced.

The principle of self-determination was especially acceptable. This is understandable in developing countries in the light of their present struggles against colonialism.

Another point that emerged from the planning discussions was the possibility of using other resources in the training programs. Another was consideration of other teaching methods besides lectures and discussions. For example, a wide variety of films was available, especially from the Canadian and British High Commissions. From lists of these, films were selected to be used as regular parts of the training program. Additional films were purchased by the Department, and some were donated by the Colombo Plan and the Asia Foundation.

While most of the films depicted standards and customs of the country in which they were produced, the transition of the principles they illustrated to the customs of Ceylon was easily made through discussions before and after the showing. The psychiatrists were particularly helpful in these discussions and regarded such well-known films as "The Feeling of Dependency," "Roots of Happiness," and "The Quiet One" as especially adaptable.

The Department's library of professional and technical books was also expanded. Lists of all books, including recent acquisitions, were circulated to the staff and the books made available on loan.

Other training programs established included a course for all the staff of the Department's institutions and a series of workshops for the heads of the voluntary institutions. In addition, arrangements were made for the chief probation and child care officers to participate in an administrative seminar given by a Colombo Plan expert.

The week-long workshop for all managers of voluntary institutions was devised as a step toward

clarifying the relationship between the Department of Probation and Child Care Services and the voluntary agencies. The Department fulfilled a licensing function in regard to these institutions but the standards established in law were low, and the institutions had full say over admission and other institutional policies. If the children who were admitted met the definitions of eligibility, a grant-in-aid from public funds was paid by the Department. Although the grant was low by standards prevailing in Western countries (amounting to approximately $5.25 per month per eligible child), it provided a major part of the maintenance cost of the institution and paid all expenses of some. The Department by law also had an inspection function, with two members of the central office staff assigned to this duty.

The workshop was focused on common problems in institutional management, with the intention of providing program ideas and suggestions on child care which the managers could then bring back to their own staff members. While reluctance and misgivings were expressed by some of the managers at first, a goodly number turned out, and considerable participation was evoked. Soon requests were received for similar workshops elsewhere on the island.

Eventually it was possible to establish these workshops on a fairly regular basis throughout the country. The chief probation and child care officers took responsibility for organizing the sessions in their respective districts, drawing on the central office staff for consultation and on the institution heads as speakers, discussion leaders and the like. At every workshop, at least one psychiatrist presented material on the dynamics of the growth process. For the majority of the institutional workers, the workshop experience was their first opportunity to meet one another and to speak of their problems, their hopes, and their experiences. It was also their first opportunity to work with the Department in a joint effort to enhance the well-being of children.

As the members of the administrative staff became better acquainted with the voluntary institutions and their personnel, they began to see that if the standards of child care were to be raised, the institutions would have to move out of their purely custodial phase and into more dynamic and meaningful programs. They also began to see the need for helping the institutions regard themselves as instruments for strengthening rather than weakening family ties, an ideal well in accord with the culture's extended family system. To accomplish this end would mean helping the institutions to reexamine their goals, to look closer at admission policies, to concern themselves with the child's parents or relatives while the child was in the institution, and to extend services to children after they left the institution. These objectives evolved as the administrators observed the workshops and as the Department officers attained greater experience in administering the Department's own institutions and in integrating the work of the field and school staffs.

One opportunity to consider the question of the institution's relationships to the child's family arose in a discussion of the institutions' programs during

Left, child care workers play with some of their charges in a receiving home for abandoned children in Ceylon. *Right,* some boys in one of Ceylon's "certified schools"—training schools for juvenile delinquents—help to construct a new building for the school. In Ceylon both types of institutions are operated by the Department of Probation and Child Care Services.

school holidays. When asked to describe their holiday programs, most of the institution managers reported that they sent nearly all the children to the homes of parents or relatives during those periods. Why then, they were asked, can these children not live permanently at home? The answers were varied: in some instances, the parents could provide only temporary arrangements for the child for short periods of time; in others, sending the children home involved risks for the child; in still others, the managers did not know anything about the child's home, especially if the parents or relatives lived some distance from the institution. This led to discussions of whether the institution had a responsibility for finding out the facts, what the best ways to do this might be, and how the ties between the child's family and the child could be furthered. During these talks, evidence of glimpses of new dimensions in child care began to appear.

Another problem frequently discussed in the workshops concerned children who did not have any relatives to whom they could turn when they were discharged from an institution. The discussion revealed that in some instances the children just "drifted away" when they had finished a certain level of schooling; the agency did not know what happened to them. This problem was discussed within the larger question of whether the institution had a continuing responsibility for a discharged child.

The suggestion was made that the employment of a graduate of the Institute of Social Work in Ceylon would be helpful in dealing with this problem. The discussants showed considerable interest in what a social worker on an institution's staff might do in strengthening family ties, in learning of changes in family situations, and in preparing the child for return to his own home. They also seemed interested in the possibilities of the social worker's assisting children who had no relatives to adjust to the world outside the institution, but they pointed out the difficulties of finding places for these children to live and the lack of employment opportunities for them. This led to a suggestion that the institution might have a joint program with the Department to establish a service home where such children could go until they were able to stand on their own feet emotionally and economically. Details of this plan were being studied at the time of the consultant's departure, although the employment of an institutional social worker had not yet materialized. The institutions were obviously beginning to examine their role and function in a broader light.

The voluntary agencies were also helped to see the broader perspectives of their task by being provided opportunities to visit and observe at one of the Department's three receiving homes, where emphasis was always kept upon the welfare of the child, with reference to his own family, if possible. One of these homes had been established in each district to provide a temporary home for children found wandering along the roadways, who had been deserted, exploited, or abandoned, or whose parents sought shelter for them. Responsibility had been given to the field staff for admission, study, and placement. While plans for these receiving homes were well underway before the consultant's arrival, the consultant helped in selecting and training the staff and in developing the program.

Whenever possible, a social study preceded admission of the children to the receiving home and, if the parents were experiencing a crisis, the children were kept in the home until the crisis had passed, with the field officer meanwhile assisting the parents in their attempts to solve their problems. In instances of children born out of wedlock, adoptive parents were sought if this was deemed the best plan for the child. For some children, usually older children, institutional care was decided upon as the best solution and arrangements were made for this care to be given by selected voluntary institutions.

Some Unmet Needs

A rather serious gap in the coordination of services and resources was revealed during a visit by the consultant to a small voluntary convalescent home for children discharged from the tuberculosis hospital. The institutional personnel were finding it difficult to return some of the children to their homes when they had recuperated for the children had, in effect, been abandoned. The usual reason given for abandonment was the parents' feeling that the institution could offer their child superior care.

Such a problem afforded opportunities to discuss parent-child relationships with the institution's staff, to help the agency workers understand what the separation from the parent meant to the child, and ways that might be worked out so that when children did return home they would not suffer a relapse. Films, such as "Roots of Happiness" and "Palmour Street," were most helpful in such sessions. While a program of parent education was more than the small institution could undertake, especially since the children came from homes located throughout the island, the possibility of employing an institu-

tional social worker to have responsibility for returning the children to their own homes was carefully explored with the institution's board.

A more complete solution to this problem and one with a preventive focus would involve use of the islandwide health department with its visiting nurses, community development resources where available, and such resources as are provided through CARE and UNICEF to work with families for the better care of children. There were some expectations that the Department's field staff would provide stimulus in the communities in which they worked to coordinate the various resources available, but the increasing caseloads, lack of community organization skills, and other factors prevented their realization.

Such efforts are also needed to combat the development of handicapping conditions such as blindness which result from malnutrition. The writer vividly remembers being shown through the children's ward of a government hospital by a highly skilled and knowledgeable Ceylonese pediatrician. The ward was full of blind and half-blind children and the pediatrician deplored the fact that he could do little in the way of prevention.

The question might be asked as to why, with the resources of international agencies available and with an islandwide health service (which makes shark-liver oil available without charge), such instances of preventable blindness in children occur. Part of the answer lies in the fact that the newly emerging nation has not had time to "catch up" with all the problems which are coming to light. Another part of the answer lies in the remoteness of some of the villages from the agencies' services and particularly of the living quarters of the plantation workers.

Many of the tea workers who live in these remote areas are illiterate, stateless Indian Tamils, a minority group which comprises about 10 percent of Ceylon's population. They lack understanding of the danger to children in such illnesses as diarrhea, and their children do not have proper care while the mother and older siblings work. Such a problem might be tackled with real success by a technical aid agency such as the Peace Corps.

In many discussions the consultant suggested foster homes as a possible child-care resource, but the proposal met with doubts about the feasibility of foster family care in the Ceylonese culture. While the practice of taking care of relatives' children for short or long periods of time is widely practiced, to accept money for this would be unthinkable to a Ceylonese couple. Some experiments were made in the use of foster homes and some of them burgeoned into institutions. A few, however, were successful.

A discussion of the possibility of foster family day care as a substitute for institutional care for some children evoked expressions of interest. If developed, this type of care might well be the opening wedge for a broader program of foster family homes. In view of the great importance given to the extended family in Ceylon, the values of foster home care would probably meet with acceptance if more widely demonstrated. Such demonstrations, however, would have to be instigated by a worker who firmly believes in this type of care.

Some General Observations

There is in developing countries an immediate need to strengthen existing services and to establish new programs as children are recognized as an important part of the population and as new changes have to be faced in the developing society. The pace that a foreign consultant must choose when caught between the anxiety to "catch up" and to hold back for fear of further dislocations is not ascertainable by any rule-of-thumb. It must be dictated by pragmatic considerations.

The consultant must be flexible. He must also have political know-how, but he cannot operate by the dictum "persuade or perish." Instead, he must present possible alternatives or fresh values. If they are acceptable and prove workable in the particular culture, well and good. If they do not, this too must be acceptable to him as long as those to whom he is offering consultation have made the choice between possible alternatives. Where the step proposed is accepted and shown to be workable, the rate at which change will take place will be determined by a number of factors, among which are the skill and the knowledge of the consultant in fulfilling his role as a change agent.

What the effectiveness will be of the measures introduced in Ceylon during the 2 years of the child welfare consultant's visit cannot as yet be evaluated. There is some indication, however, that children are beginning to be regarded as distinctive personalities with individual potentials for growth and development, and this, of course, is the beginning of "welfare." Ceylon, like the other nations of the world, needs a citizenry which can function at its best in order to face the many problems of tomorrow.

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[1] Yankauer, Alfred: Intercultural communication in technical consultation. *Children*, September–October 1959.

MENTALLY RETARDED TEENAGERS IN A SOCIAL GROUP

SIDNEY GERSHENSON
Former Group Worker

MEYER SCHREIBER
Director of Group Work Services

New York City Chapter, Association for the Help of Retarded Children

CHILDREN LEARN to live with others only through experience. However, the retarded child is often caught in a vicious spiral that is negative and limiting to his social development. The lack of social experiences leads to social retardation and ineptness in chronologically appropriate social skills, accompanied by emotional difficulties arising from feelings of rejection and deprivation; and the lack of social skills further limits the opportunities the retardate has of participating in social experiences.

Mentally retarded children must be taught many things which normal children learn spontaneously or incidentally. Often they must be taught to play and to be helped in developing creative qualities that give them fun and pleasure. When this has been achieved the retardate can gain the same satisfactions from participating in social activities as other people. These satisfactions derive from: (a) being recognized and accepted in the group situation; (b) a sense of accomplishment in activities in which he is successfully interacting with his peers; (c) the experience of self-expression, especially when making positive contributions to the group's activities; (d) the enhancement of self-esteem; (e) and the feeling of "belonging."

To give young retardates these opportunities, the New York City Chapter, Association for the Help of Retarded Children has conducted a group work, recreation, and camping program for mentally retarded children, teenagers, and young adults for the past 11 years. At first the program was directed by a social caseworker, but for the past 5 years it has been the responsibility of a professional social group worker who spends full time on the job.

The program was developed on a decentralized basis in whatever facilities were available in neighborhoods throughout New York City—churches, synagogues, schools, park buildings, housing projects, and veterans and union halls. It includes groups of elementary school-age children, teenagers, and young adults. In placing individuals in the groups, chronological age, previous social experiences, and social adequacy and functioning are considered together. Trained group workers are used as group leaders, assisted by a nonprofessional person of the opposite sex who may be a staff member or a volunteer.

The purpose of the program is to provide:

1. A medium of enjoyment for mentally retarded children and youth.

2. A setting which will aid them in social adjustment—one which provides a small, intimate, face-to-face experience with others of the same age, including members of the opposite sex.

3. Experiences to help them develop simple, useful skills that they can carry over to the home, to the community, and perhaps to employment.

4. Experiences to help them accept themselves and the limitations imposed by their retardation, as well as to utilize their capacities to increase their feelings of self-worth.

5. A means of freeing parents for a few hours weekly of the supervision of the retardate and of helping them to carry over into the home and community attitudes that will promote increased independence in their children.

One of these groups is the Queen's Teens—a coed social club of adolescent retardates 12 to 15 years of age, one of 12 such groups throughout the city. The group meets each Wednesday evening from 7:30 to 9:30 p.m. in the basement recreation room of a large cooperative housing project in a middle-class neigh-

borhood in the borough of Queens. The location of the meeting place is far from ideal—neither having the facilities of a community center nor offering potential contact with other children, but it is adequate.

The membership of the Queen's Teens reflects the socioeconomic character of the middle-class neighborhood.

The New York City Chapter, Association for the Help of Retarded Childred provided the overall program structure, supervision, and administration, which in this instance included the paid male leader, special interest and holiday programs, and program supplies. A women's auxiliary affiliated with the New York City Chapter supplied two female volunteers a week, refreshments, and occasional special program needs.

Composition of Group

Members were referred to the group by the New York City Chapter after their application had been processed through intake. The intake process included an interview by the director of group work services with the young person and one or both parents at the office of the Association. Before the interview, information about the child's development and his family situation was obtained from school records, clinic material, and other sources. Criteria for membership in the Queen's Teens were: (a) membership of the parents in the Association for the Help of Retarded Children; (b) chronological age, 12 to 15; (c) the ability to participate at the level of the group; (d) the capacity to derive benefit from the group experience. Eligibility in relation to the last two criteria was determined only after the teenager had participated in several group meetings. The final decision was made by the Chapter's director of group work services, the leader of the group, the parent, and the teenager himself to the extent of his ability to understand.

Within the 8-month period on which the observations in this paper were based, a total of 19 teenagers were referred to the group. While the aforementioned criteria identified this as a "formed" group, it contained some elements of a "natural" group in that its members referred to it some of their classmates from school. (Most of the young people attend special public school classes for the retarded.) The group became stabilized at 10 members, with an average attendance of 8 or 9 youngsters at each meeting. Of those who did not continue: one was found by the leader to be functioning at a higher level than the group; another chose not to come because he himself felt the group was too young for him; one child had no means of transportation; three teenagers never attended because their mothers were not interested in the group after visiting the meetings; one youngster was asked not to come because his attendance was irregular, averaging less than once a month, and his behavior when present was disruptive to the group.

The teenagers who remained in the group came regularly to meetings not only because of interest in the group and the program, but also because the parents assumed the responsibility for bringing them. Only two of the members lived within walking distance, the others being scattered in a 5-mile area.

The children's IQ's ranged from the forties to the seventies. This information, however, was found to be of little use in planning recreational activities for the group, for it did not give any indication of the young people's ability to function in a social group. What was of greater importance in program planning was the youngsters' ability to relate to adults and peers, to work and play with others, and to use program materials. At present there is no meaningful measure of this type of ability available.

A scale rating the children on the nature and extent of their social functioning and adequacy would be of great help in the selection and placement of individuals in social groups. There appears to be a distinct difference in the individual's intellectual level, his chronological age, and his social functioning. We found that the child who had previous positive social experiences functioned better in the group, regardless of his intellectual level.

Program Structure and Content

In programing for the "QT's" the emphasis was on the provision of both social and learning experiences which to the participants would be regarded as exciting, satisfying, and full of fun. The group worker and the volunteers worked with the youngsters in an uncritical and supportive manner in regard to their participation while attempting to further their development in the areas of self-care, use of program activities and materials, interaction with their peers and adults, and self-expression.

The group was called a "club" on the assumption that the term would have status significance to the adolescents. The group worker took the responsibility for planning a program and modifying it to both the group's and the individual's readiness at the time of the meeting.

The activities relied upon were the kinds common to recreational groups—loosely organized games, square and folk dancing, singing, arts and crafts. In addition, activities involving the retardate in learning a functional task related to everyday living were included and were especially popular. These activities included (1) short trips in and around the immediate community; and (2) preparation of refreshments. The trips included shopping in the supermarket, buying sodas and cakes in a local cafeteria, walking to the park, riding the subway, and eating lunch in the automat. The supermarket and cafeteria trips provided the basis for later role playing as waiters, clerks, and customers.

The volunteers were responsible for selecting and bringing refreshments that the children could prepare for themselves. They started with caramel apples and popping corn and moved to chocolate and tapioca puddings, pizza pies, vegetable salads, hot dogs, and stuffed celery. The parents were especially impressed by the skill their children developed in these activities.

Special projects—puppet making, mad-hatters ball, birthday parties, and celebration of holidays—were also successful.

Each 2-hour meeting was planned to allow for individual participation both in choosing and leading activities. The breakdown and approximate time involved in each session were as follows:

1. **Premeeting** (15 minutes). While the group was gathering for the evening, the teens moved about the room playing with various games and equipment. During the period of initial development these were set up before the young people arrived. Later the young people helped the worker to get the room ready for the evening.

2. **Meeting** (15 minutes). The group worker would call the members to come and be seated around a table. The "meeting" opened with a set of seated circle games used regularly from week to week. After this opening the group worker asked the members to tell about their individual experiences during the week and encouraged them to talk about their other interests, with the purpose of engaging the individuals in informal conversation, allowing for and stimulating interaction between the members themselves and the adults. In addition, the evening's activities were planned at this time.

3. **Maior activity** (30 to 45 minutes). The theme of the evening was developed and carried out during this period—parties, walks in the snow, games, or arts and crafts.

4. **Refreshment period** (30 to 45 minutes). While the members ate the refreshments which they had helped prepare, the group worker and volunteers engaged them in individual informal conversations. Afterwards the members helped in cleaning up.

5. **Closing period** (30 minutes). The program ended with singing, dancing, or a game or two. Then the group worker made an announcement about the following week. Before going home the young people helped to put away the program equipment and made a game of folding and stacking the chairs. The group worker and volunteers always greeted the parents as they arrived to pick up their youngsters.

Some Observations

From the experience with Queen's Teens one could draw some general observations on group work with the retarded:

1. ***Retardates, like other individuals, can be expected to react differentially to group experiences.***

Contrary to a common belief that retardates tend to be passive and overconforming, the group worker found evidence among the Queen's Teens of a normal range of behavior. For example:

Mary, Jane, and Alice can be counted on to do whatever the group wants to do or what the leader suggests. They always vote as the others and never do anything on their own or in disagreement with the others. They seem too insecure to express their own wishes. Yet, when a decision was left up to the three of them and nobody else, one of them came forth with a suggestion that the others followed.

* * *

In contrast, Bob, Jim, Dick, and Lottie act completely independently, participating in the group activities only when they want to. They seem to regard the meeting as an opportunity for individual self-expression. Jim, for example, entered the room one evening saying, "Leave me alone tonight; I don't want to play." He then moved away from everyone and began walking around the room by himself. When he got tired of doing things by himself, he came back into the group and participated in activities with the others for the rest of the meeting.

Thus, some of these young retardates found in the group experience a chance not only to do things with the others but also to express their individuality by choosing when and where they would participate. As long as an individual's expression of independence was not disturbing or limiting to the others in the group activity, it was respected and encouraged by the leaders.

2. ***The individual's needs take precedence over the group's needs.***

The group worker found that often the actions of an individual were more important to deal with than to keep the group activity going—for example, when Larry threw a tantrum because he was not

Group dancing is one of the activities enjoyed by the Queen's Teens, a social club for retarded adolescents in New York. Here they participate in a dance with their group leader.

allowed to dominate the group in playing a game; or when Bob kept running around screaming.

However, in such instances, after the group worker stopped the group's activity in order to deal with the individual he would involve the entire group in the discussion of the situation. In that way the problem of the individual was woven into the program of the group.

Often independent actions were expressive of creative urges or moods rather than the acting-out of hostility or anxiety. Thus, Bob rushed to the piano and banged away loudly while the group was singing *She'll be Coming 'Round the Mountain*, and at another time Jim listened quietly to a phonograph record while the group played tag.

At such times, the group worker adapted the group's activity to involve the independent individual in a positive and encouraging manner: With Bob—"Let's join him at the piano and sing while he plays," applauding his efforts when the song ended. And with Jim—"Jim, will you help us play musical chairs by turning the record on and off while we play?"

In both these instances the individual moved with the group into the next activity after such an approach.

When it was not possible to adapt the group's program to an individual's independent behavior, the individualist was asked to stop what he was doing but with the condition that later on he could come back to finish what he had started. In essence the group worker was saying that he thought the individual was as important as the group.

3. ***Program is planned to provide individuals with opportunities to experience success.***

It was assumed that a successful experience in participating in the group's program would loosen the individual's inhibitions and give him the security to participate in the program more fully. Therefore, games were modified so as to give everyone a chance to win. Arts and crafts projects were always admired if the individual himself liked what he produced. The group worker made a practice of informing each parent—in front of the child—that their child had done quite well that night in the group.

In playing "choosing" games sufficient control was provided by the group leaders to assure each teenager a chance to be both chooser and chosen.

4. ***Expectations of the level of an individual's performance must vary in relation to the intellectual, social, and emotional aspects of behavior.***

Among the Queen's Teens the group worker assumed an uncritical role in relation to a child's intellectual performance. However, when it came to cleaning up, putting on coats and hats, getting chairs, he was more demanding. The level of expectation of course differed for each child, according to the child's physical and motor coordination. When the child did not respond as expected, the issue was dropped and taken up at a later time when the child seemed more cooperative. For example:

Laura who is almost blind was given a record to place upon the phonograph. (Her mother had mentioned earlier that she had never done this at home.) Because of a spastic condition, Linda had very poor motor coordination, but she was able to get herself to the record player, place the disk on the turntable, and almost get the needle in the right groove. She exhibited great pride in this accomplishment.

* * *

Alfred, an obese and overprotected child, was afraid of going out into the snow. He said he would catch cold or he would slip and break a leg. It was a difficult task to get him outdoors—one which involved seeing him through three tantrums—but after this was accomplished, he became more amenable to other trips away from the building.

5. ***Group activities must be carefully selected to suit the functioning level of the group.***

For the Queen's Teens the group worker chose familiar games which the young people knew and liked. New games were also introduced but modified to suit the group and allow for successful play.

Among them was a clapping rhythm game that is popular with adolescents generally. It took 3 months for the group to learn this game, but they did learn it and liked to play it so well that they made it part of the opening portion of each meeting. Regardless of the type of activity, the presentation was always geared to the level of the group members in order to minimize frustration and provide for satisfying participation.

Group Worker, Individual, and Group

While the retardate benefits from experience in a social group, he evidences a slower than normal development in social skills. It is up to the group worker to remain "enthusiastically patient" during the long, slow process of gradual improvement. While enthusiasm and warmth are important factors in work with any group, they are even more important in work with retardates. Parents and teachers of retardates, because of the demanding nature of their responsibilities, may at times have their enthusiasm worn thin. Yet, like everyone else, the retardate needs people around him who are stimulating and enthusiastic.

In spite of the necessity to suit the activities to the group, it is not necessary to "talk down" to the retarded. The leader talks to them in the same manner as he would to other adolescents.

On the other hand, because the retardate is limited in social experience, it is necessary for the leader to have a highly structured program plan that remains similar from week to week. As the participant becomes more accustomed to the pattern, he begins to anticipate what will come next, deriving much satisfaction from this accomplishment.

Experience with the Queen's Teens, and other groups of mentally retarded formed by the Association, indicate that while individuals change within the group, there is some group movement toward higher levels of activity. Individuals, however, do learn to participate in activities with their peers, and in social adequacy appear to move closer to the social expectations of their chronological age.

The Queen's Teens is now in its third year of existence. In this third year we have noted some movement toward subordinating individual needs to that of the group; in the ability of the group to carry out a short "business" meeting; in the individual's ability to take on more responsibility for his own behavior and for planning together with the other members; and in the ability of the group leader to lessen the active nature of his role in the knowledge that the group could take more responsibility in regard to simple activities.

The Association, in extending its program to serve additional groups in different parts of New York City, has found that variables such as previous group experience, religion, culture, and socioeconomic and minority group status have an impact upon a group experience for the retarded adolescent, although there are still many unknowns in this regard. In some families of low socioeconomic status, retardation of a child may be only one of the many other serious problems affecting the family and is not therefore always perceived as a crisis situation, as it is apt to be in middle-class families. Many retarded adolescents in such families, who are in the higher functioning range of retardation, seem to have much in common with their normal contemporaries and to have acquired some social skills in the process of daily living. Barring gross stigmata, their intellectual deficit or perceptual difficulties are the most obvious signs of their retardation to the group worker.

In the group situation, these young people need a great deal of help in planning and following through on responsibility for program development, as did the Queen's Teens, and again structured program is helpful. However, relationships are formed more readily between the members who are of the same socioeconomic or cultural background in view of their having similar experiences in school and in the neighborhood. The members also relate more easily than those in such groups as the Queen's Teens to other young people who use the group service agency, as they generally share a similar background. These young retardates also seem to have greater interest in energetic activities, especially athletics, and less fear of risking injury. They have had more exposure to group experiences with their peers, both retarded and normal. This is probably due to less maternal overprotection.

As additional experiences are accumulated with such groups and analyzed, the findings may not only help to refine social group work method with the mentally retarded, but bring to light additional information about social development patterns and the use of leisure time and about what kind of interaction patterns occur between retarded and normal individuals as well as between retardates.

THE PHYSICIAN AND PARENTS OF THE RETARDED CHILD

J. WILLIAM OBERMAN, M.D.
Director, District of Columbia Clinic for Retarded Children,
Bureau of Maternal and Child Health, District of Columbia Department of Health

DURING the last 12 years much progress has been made in assessing the potential ability of the retarded child, and applying this toward the development of community programs to help him realize this potential. Sparked by the National Association for Retarded Children and given major impetus by programing and funds from the Children's Bureau, a mushrooming of multidisciplinary clinics devoted to diagnosing and planning for the retarded child has occurred throughout the country. These clinics examine the child from medical, social, psychological, and educational points of view, interpret to parents the nature and magnitude of the condition, and attempt to set up a comprehensive plan for future management of the child.

However, many children are taken long distances to clinics for the mentally retarded by their parents, and after confirmation of the diagnosis return to their homes where professional persons who have specialized in work with retarded children may not be available. Thus it remains to the family physician or pediatrician to counsel and advise the parents as their mentally retarded child grows older.

What can the family physician or pediatrician do when presented with a child obviously mentally retarded or one suspected of being so, if in his community such specialized services are not available? Does helping the parents and child require a vast body of information which he cannot hope to have at his command? Must he take extensive refresher courses in mental retardation to answer the inevitable and seemingly interminable parental questions about the child and his future?

When the retarded child is passing through the first few years of life, it is most difficult for any person to answer the questions of ultimate prognosis uppermost in parents' minds. Nevertheless, these early years are crucial for the child, since during this period of life his basic personality patterns begin to emerge. If in addition to a delay in development the retarded child must cope with a liberal dose of parental anxiety and feelings of helplessness, his entire adjustment can be channeled into areas of behavioral abnormality which will lead inevitably to early institutionalization.

The pediatrician or family physician who sees retarded children can and must play an important role during these early years. By virtue of his training and experience in normal child development, he can contribute to the normal personality development of the retarded child, especially if he already has an established relationship with the family and has gained their respect and confidence. Through his knowledge of the home atmosphere he can anticipate problems that may arise and can give the parents many practical suggestions for managing the child. Many parents who, because of their feelings of guilt and anxiety, would not be able to seek help from a child guidance clinic or social agency can lean on the strength of their family physician or pediatrician, and thus accomplish many changes in their behavior toward the child even though they do not gain any real insight into their own feelings. Direct suggestion, even when it conflicts with basic parental feelings, can often be accepted.[1]

The birth of a child is a momentous occasion in the life of a family. Long before birth, parents idealize the child and make elaborate and often fanciful plans for his future. Many parents see their child as an extension of themselves and as an opportunity to live out their own fantasies and wishes. While many normal children do not live up to the often unrealistic expectations of their parents, who therefore must gradually relinquish their cherished plans, par-

ents who receive a diagnosis of Mongolism at their child's birth or mental retardation early in life have their dreams and fantasies brought to an abrupt end. Thus, when a diagnosis of mental retardation is made, it is the parent who suffers a blow rather than the child.[2]

Consequently parents who seek help for a retarded child are usually in a state of heightened emotions. They frequently expect and fear the worst, and are already calling forth the usual feelings of shame or guilt which people suffer if something goes wrong in connection with the birth process. One recent study of the initial subjective reactions of a group of parents whose children had been diagnosed as mentally retarded has shown that about half expressed feelings of rejection toward the child associated with shame or guilt, and a large proportion of the others worried about reactions to the child of their other children, relatives, and friends.[3] Some parents are unable to overcome their frustration and disappointment at the child's inability to attain their ambitions for him; he remains a source of irritation to the family and may even precipitate its disruption.

Diagnosis

When the physician first suspects Mongolism in a newborn infant, he may want to seek confirmation of his diagnosis by consultation with a colleague. His next step must be to interpret the diagnosis to the parents during the neonatal period or shortly thereafter, preferably to both of them together. After the initial shock has subsided, the parents will inevitably deluge him with questions concerning the "why" and "how" of it, and having to do with the child's chances for health and adjustment in later life. In addition to talking these problems over with them in considerable detail, he may find that providing them with a copy of the booklet "The Mongoloid Baby,"[4] which answers the questions most frequently asked by parents on this subject, is a great help to them.

In the case of the nonstigmatized retarded infant the diagnosis is usually one gradually suspected, frequently not until after the child is a year old. The physician then has the difficult task of deciding whether a developmental aberration is a physiological variant or is, in fact, true mental retardation. Perhaps the most pertinent finding in early diagnosis is the observation, as recently noted by Illingworth,[5] that the child who is mentally retarded from birth or shortly after birth *is behind in all fields of development* except occasionally in the gross motor field. On the other hand, the child retarded only in a specific field of development (walking, talking) may represent only a physiological variant and should not be considered mentally retarded unless his further course of development so indicates. When a suspicion of mental retardation arises, the physician should seek the services of a qualified psychologist to confirm his impression or refer the child to a multidisciplinary evaluation clinic if one is available.

Without entering into the controversy of the reliability of infant testing as a predictor of future intellectual potential, this author is in agreement with those who believe that the great majority of infants whose development is found to fall *within the mentally defective range* (Developmental Quotient less than 70) in the first 2 years of life are likely to be found to be mentally retarded in later years.[6] Certain premature infants of low birth weight, infants with a history of "maternal deprivation," and those with chronic debilitating physical disease may be important exceptions. When there is uncertainty, psychological testing repeated 6 to 12 months after the initial tests may clarify the diagnosis.

However, when a diagnosis of mental retardation has been made and interpreted, the physician's work has just begun. Many physicians do not relish the task of helping parents with retarded children because they feel that there are serious gaps in their knowledge of the growth and development of the retarded child. But they do have considerable knowledge of *normal child development* and can bring this to bear most satisfactorily on the management of the *abnormal child.*

Telling the Parents

When the physician tells the parents about a diagnosis of mental retardation, he frequently meets with denial, and then sometimes becomes the target for parental criticism and hostility. This is particularly true if he presents the diagnosis only, giving no suggestions as to how the child should be handled or what kind of plan should be made for him. In a recent study, Koch and his co-workers[7] have commented on the frequent dissatisfaction of parents with the way pediatricians and general practitioners deal with the problem of the mentally retarded child and on the parental bitterness toward what they regard as the cursory nature of the examination and presentation of facts. In the case of the non-Mongoloid child, who seldom exhibits recognizable physical abnormalities, parents and physicians fre-

quently arrive at a suspicion of mental retardation together. However, the parents often become anxious long before the physician, who sometimes retreats behind the phrase "he'll grow out of it." When the diagnosis is eventually made, the parents often express animosity toward the physician who did not listen to their fears.

Some physicians react to the diagnosis of retardation in a child with an abrupt recommendation for institutionalization. While this may be indicated in some situations, the recommendation is a far-reaching one and should be made only after such factors as attitudes of the parents toward the child, the social background of the family, the welfare of the child's siblings, the economic status of the family, and the availability of satisfactory institutions have been taken into account. Such a recommendation is often made without considering the possibility that the retarded infant may profit considerably from the mother-child relationship in the first years of life and that his presence in the family is not likely to interfere seriously with the normal emotional development of older or younger siblings. Studies such as those of Schipper [8] and Saenger [9] have emphasized the good adjustment of many retarded children and young adults living with their families.

Helping parents face up to the diagnosis cannot be done quickly. For example, at the District of Columbia Clinic for Retarded Children, which provides continuous followup services to retarded children and their parents as long as they are requested, the initial interpretation may take as long as an hour to an hour and a half. During this time the parents are encouraged to express their feelings of hurt and disappointment as well as to ask any and all questions concerning the child's future potential. And the clinic's services to parents do not end with the initial interpretation. Many parents receive brief or continuing social casework in order to work out their feelings; the child development specialist sets up home training regimens; [10] parents are seen in groups so that they may explore their mutual feelings toward their children and how to deal with problems of behavior and development; [11] brief psychotherapy is made available to selected children; and a variety of other services are given. Parents are encouraged to contact the clinic at any time the child exhibits a developmental crisis or at any time educational or training plans are indicated.

Thus, the actual evaluation is both a learning and a therapeutic experience for parents since they have a chance to air their views of the child's deficiencies and to compare his development with the development of normal children. Rarely after this is a parent unable to realize, at least intellectually, that his child is retarded.

However, we have found subjective parent reaction at the time of interpretation at the clinic to vary from complete acceptance of the clinic's findings and whole-hearted cooperation in planning for the future life of the child to one of complete rejection and subsequent "shopping" to other agencies. Some parents persist in their fantasies that the child will "grow out of it" and that the retardation is not as severe as the clinic has found. They frequently use the interpretation session to criticize one or more aspects of the evaluation and to ignore many of the findings.

Counseling and Time

Curiously, during this often very emotional session, parents seem to be directing their comments to the world at large rather than to any specific clinic member—their reason tells them what their feelings will not allow them to believe. Particularly is this true of fathers, who frequently cling to the hope of future normality. It is at this time that counseling, whether given by a trained social worker or by any other professional person with the ability to listen, sympathize, and respond wisely, is most valuable.

It is this author's impression, however, that even following a careful evaluation and continuing followup service by skilled personnel, the most important factor in the ability of parents to plan realistically for their child is *time*. Many parents, while initially rejecting the diagnosis, after a period of time in the home, where they can appraise the child and compare him to his normal siblings and playmates, are able to see and to say that their child is abnormal. An important element in the effects of time is the fact that the retarded child of preschool age *passes through the same stages of development as do normal children*, even though at a slower rate. For instance, when a parent has been able to observe his child's attainment of a particular self-help skill such as toileting, he is able to say to himself that the problem is not after all hopeless. Being more hopeful, he is at the same time more able to admit that his child is retarded.

Many parents who have initally rejected the diagnosis of mental retardation return to the clinic a year or so later proudly demonstrating the recently learned skills of their child. Some parents who are

unable or unwilling to talk of their disappointment or guilt at having produced a retarded child are able to focus on his accomplishments and plan ahead for his future life. It is most important, therefore, that the "pot be kept boiling" during the early developmental years when the child who ultimately will have great difficulty in school can be compared more favorably with his normal siblings.

Anticipatory Guidance

How different is the retarded child from normal children in the preschool years? In one sense he is no different. For, while his rate of neuromuscular development is delayed, the stages through which he passes are the same. As the normal child does, he will sit before he crawls, crawl before he stands, and stand before he walks. At the time of walking he is most likely to respond to attempts to toilet train him. Thus, the physician with even rudimentary knowledge of child development can give the parents "anticipatory guidance" by applying this knowledge to interpret the next step in the training of the child. He can supplement his interpretation by giving them easily obtainable and readable booklets on normal child development [12, 13] which deal with many of the needs of parents of a retarded child in the preschool years.

The frequent contacts with parents and child provided by ordinary well-child visits provide a natural setting for discussions of developmental problems. In these, the physician need only provide continuing sympathy, support, and encouragement to the family. While advice should be geared to the level of parental anxiety, it should always be presented in terms of normal stages of development. The parent can compare his child's progression in these stages with those of normal children, especially if the child has older, normal siblings, and see that after all this is first and foremost a child—a handicapped child, to be sure, but a child nevertheless.

The services of public health nurses are invaluable in helping parents of retarded children, especially when they visit the home and provide practical advice and demonstrations of how to set up self-help routines—self-feeding, toileting, dressing. This not only helps the mother in managing the child but also indicates that someone is interested in her problem and is willing and able to help her meet it. Information contained in such booklets as "The Mentally Retarded Child at Home" [14] also proves quite useful in this respect.

In talking with the parents it is not necessary to use scare words such as "brain damage" or highly scientific phrases which the parent may misinterpret or not understand. Parents should be encouraged to watch their retarded child grow and to enjoy him just as they would a normal child, treating him in terms of his mental age and allowing him to progress at his normal rate of speed. "Behavior problems" encountered in the preschool period are most often characteristic of the developmental stage for the child's mental age or a reflection of abnormal pressures applied by parents who are treating him as a child of his chronological age. The younger a retarded child when diagnosed and the earlier the physician is able to help the parents set up simple regimens in the home, the greater is the likelihood of a child's developing a healthy personality and being able at school age to adapt to and enjoy the school setting for which he is qualified.

The occasional hyperactive, distractible, retarded child whose retardation has an organic basis presents special problems in management by virtue of his speeded-up pace of living and requires a modified approach involving firmness and limit setting, techniques often alien to many parents. The paradoxical effects of such central nervous system stimulants as dextroamphetamine and methylphenidate are frequently very useful for quieting the hyperactive behavior of such a child.

During his contacts with the family the physician must continue to remember that the parents' acceptance of a child's mental retardation will be gradual. Whether or not it proceeds at the rate he thinks it should, the important thing to watch is whether the parents are following through with plans for training in self-help skills and are treating the child in a way that will foster a healthy personality development. Each parent must find his own way to this acceptance, and there are as many different ways as there are parents.

The physician should be prepared to keep his own plans for the child flexible. For example, he may feel that a young child's place is with his mother in the home all day, failing to realize that the presence of a child who remains an infant for a long period of time may be a chronic source of physical and emotional strain on the mother. A substitute mother in a daytime foster family home or day-care center can allow the mother the breathing spell she needs. Should the physician at any time become aware of increasing parental tension or inability to deal with the child in the family, referral of the parents to an

appropriate community family service or child welfare agency for counseling or planning for institutional placement is indicated.

As the child grows and approaches the age at which children need group experience, the physician should try to help the parents find a nursery school in the community which will accept retarded children, to help prepare the child for entering a specialized class in the public school. Helping the school-age retarded child more and more becomes the responsibility of the educator and vocational rehabilitation worker as the child grows older, the physician's role becoming one of normal health supervison. With optimal care and training many retarded children as adults become productive members of society, and when they do the physician can look back with pride at his role in fostering their normal personality development in the preschool years.

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[12] Spock, B.: Baby and child care. (Revised edition, paperback.) Pocketbooks, New York. June 1962.

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Mental retardation ranks as a major national health, social, and economic problem:

It afflicts twice as many individuals as blindness, polio, cerebral palsy, and rheumatic heart disease, combined.

Only 4 significant disabling conditions—mental illness, cardiac disease, arthritis, and cancer—have a higher prevalence, but they tend to come late in life while mental retardation comes early. . . .

The untold human anguish and loss of happiness and well-being which result from mental retardation blight the future of millions of families in the United States. An estimated 15 to 20 million people live in families in which there is a mentally retarded individual. Economic costs cannot compare with the misery and frustration and realization that one's child will be incapable of living a normal life or fully contributing to the well-being of himself and to society in later life.

From "A Proposed Program for National Action to Combat Mental Retardation," a report to the President by the President's Panel on Mental Retardation, October 1962. ***(See page 123 of this issue.)***

A report from England . . .

TREATING SCHIZOPHRENIC MOTHERS WITH THEIR BABIES

A. A. BAKER, M.D.
Consultant Psychiatrist, Banstead Mental Hospital
Sutton, Surrey, England

ONE of the most interesting pieces of current pioneer medical work in England is being carried out at Banstead Mental Hospital, Surrey. This hospital has a mother and baby unit for the care of schizophrenic mothers admitted with their babies. The unit was opened 4 years ago, following several years' research into the behavior of schizophrenic mothers after discharge from a mental hospital. This research was reported at the Second International Conference for Psychiatry at Zurich in 1957. Contrary to popular belief, it showed that schizophrenic mothers rarely try to harm their children and that the policy of separating them from their babies often causes more difficulties than it solves.

The unit is a small one, taking up to eight patients; the hospital as a whole serves a population of about three-quarters of a million, but this population does not always provide sufficient patients to keep the unit full, so that other schizophrenic mothers are occasionally taken from another area to fill empty beds. Schizophrenic patients have their own particular difficulties and there are some advantages in treating them in a group by themselves.

The patients are either referred by obstetric departments or general practitioners, if the patient has returned home. The unit will accept any mother who has a schizophrenic illness provided the baby is still under 1 year old. The unit is particularly intended for the severely disturbed mother whose management is impossible outside a hospital; about one-third of the mothers are admitted under compulsory orders. The unit, nevertheless, is quite open and there have been no significant difficulties in the management of the most severely disturbed patient.

Physical treatment, particularly E.C.T. (electroconvulsive therapy), and tranquilizers are used vigorously in the first few days after admission until the acute symptoms have subsided. Treatment intensity is then reduced over the ensuing weeks though most mothers receive about 20 shock treatments, and on discharge will still be taking a maintenance dosage of tranquilizer. The nursing staff consists of two trained psychiatric nurses per shift in addition to nursery nurses whose function is to supervise and help the mother care for her baby. Some mothers require no help in this; but a patient in stupor may be able to do very little for her baby for some days so that the nursery nurse may have to take complete charge of the child.

Breast feeding is maintained as far as possible. It has been found that patients can successfully breastfeed while in stupor and also that breast feeding is unaffected by shock treatment and tranquilizers which, if anything, seem to increase milk production.

Structured Environment

The psychiatric nurses are trained to treat each patient as an individual. In general, most schizophrenic patients need a clearly structured environment with fairly rigid rules when first admitted, though this situation is relaxed as the patient progresses until she has full freedom by the time of her discharge. Most patients—even the most severely disturbed—have improved sufficiently to go on weekend leave 2 weeks after admission. The psychiatric nurses also learn that the patient's problems involve her whole family. Therefore, the nurses spend much time in discussions with visitors. Every day is visiting day. Most husbands come daily and other relatives, including in-laws, visit on occasions. Family emotional patterns often become dramatically clear under the influence of a puerperal psychosis in a young mother.

The social worker is expected to investigate every patient's home situation and conduct home followups after discharge in every case. Some patients, however, live too far from the hospital to make this possible. As would be expected, the relapse rate among these patients is much higher than the relapse rate in the patients for whom adequate followup is possible.

In addition to day-to-day discussion of immediate problems, there is a weekly meeting of all the staff of the unit, including doctors, nurses, social workers, and, if relevant, psychologists. In this meeting the staff reviews its total knowledge of the patient and her progress and also the progress of patients who have left the unit.

At times, two children of the same mother—a baby and a toddler—have been admitted. There are serious disadvantages to this arrangement. Schizophrenic mothers have greater difficulty than most in dividing their attention between the baby and the toddler. They have a specific problem in correctly assessing the age and needs of their children, and the presence of two seems to add to this confusion. In general, we feel that the father, or other relatives, can usually make satisfactory arrangements for toddlers and that, in the long run, this is to the

childrens' advantage and leaves the mother to concentrate on her baby.

It has been shown by comparison with a control group that those mothers treated with their babies not only make a better recovery, but are less likely to relapse: 100 percent of those treated with their babies left the hospital able to care for their babies, compared with 60 percent of the mothers in the control group who had received treatment from the same psychiatric team but who did not have their babies with them.

The evidence to date suggests that the arrangement is also to the advantage of the baby, who suffers less disturbance through changing hands at the time of the mother's admission and, of course, does not have to adjust to a strange mother when the mother returns home from the hospital. Long-term followup will show whether there are similar advantages to the family as a whole. Certainly, evidence to date suggests that the children in these families are less likely to be disturbed by the mother's illness than the children, for example, of neurotic parents.[1]

The following is a typical case:

The patient was a Belgian woman who had come to England as a girl and married an Englishman. There was no history of mental illness in her family. Before her illness she had been a friendly and competent woman of above average intelligence. She spoke good English and, superficially, had adjusted to the English culture.

The patient had had her first baby in a general hospital where she had suffered considerable anxiety and uncertainty about the behavior expected of her. In fact, she had become so anxious that she had begun to question the behavior of the nurses and whether they were doing the right things for her. She had then been placed in a single room, which increased her anxiety. Finally she had become so "difficult" that she was sent home prematurely lest she disturb other mothers. At this point, in spite of her strange statements and obvious paranoid attitudes, the possibility of mental illness had not been considered. At home she had been unable to sleep, had become progressively excited and confused, and eventually—2 days after her return—had assaulted her husband and had run down the street unclothed. She was admitted to our unit with her baby.

On admission, this woman expressed obvious paranoid delusions—believing that her food was being poisoned, that people were spying on her, and that other attempts were being made to harm her—together with a general paranoid attitude. She exhibited incongruity of affect and thought disorder of a schizophrenic type. She continued to breast feed her baby, and eventually made an excellent recovery on electroconvulsive therapy together with a tranquilizer. She was discharged home after 10 weeks, and 18 months later was discharged from the outpatient clinic. She remains fit and is a good mother.

This woman's husband was found to be a rigid, rather inadequate man, who was extremely upset by his wife's illness and appeared to have no insight into it. On his second visit to the unit, his own behavior was so strange that he was admitted to one of the male wards. He, too, had a schizophrenic episode at this time, which responded to treatment, and he returned to work within a few days; apart from his personality limitations he has given no further cause for anxiety.

As in this case, change of culture or domestic pattern often seems to be associated with schizophrenia following childbirth. The case also illustrates the severe stress experienced by some husbands when this condition occurs. Several husbands have produced overt symptoms themselves when their wives have become ill, which have improved as the wives recovered.

A long-term followup of the cases treated in our unit, over at least a generation, is proposed. It does seem from the initial results that this type of unit not only provides therapeutic advantage to the patient, but to the family and community as well.

[1] Cowie, Valerie: The incidence of neurosis in the children of psychotics. *Acta Psychiatrica Scandinavica*, vol. 37, no. 1, 1961.

Guides and Reports

CHILDREN AND THE THREAT OF NUCLEAR WAR. Sibylle Escalona. Child Study Association of America, 9 East 89th Street, New York 28. 1962. 28 pp. 40 cents, with quantity rates available.

Reports some observations on the psychological impact of the nuclear threat on children, suggesting ways that parents and educators can deal with children's questions about the subject.

THE CHURCH NURSERY; a guide for health and safety. Maternal and Child Health Division, Michigan Department of Health, Lansing. 1962. 7 pp. Single copies free on request from the Michigan Department of Health.

Suggested standards for facilities and operation of nurseries established by churches to care for children under 2 while their parents attend services.

RECENT ADVANCES IN DEGENERATIVE DISEASES OF THE CENTRAL NERVOUS SYSTEM IN INFANTS AND CHILDREN: report of the 42d Ross Conference on Pediatric Research. G. M. Owen, editor. Ross Laboratories, Columbus 16, Ohio. 1963. 104 pp. Limited quantity free on request from Ross Laboratories.

Fifteen scientific papers presented at a conference held in April 1962 under the auspices of the University of Oklahoma Medical Center.

DAY CAMPING FOR THE MENTALLY RETARDED. David Ginglend and Kay Gould. National Association for Retarded Children, 386 Park Avenue South, New York 16. 1962. 55 pp. 25 cents.

A guide outlining the value of day camps for retarded children; elements to be considered in organizing these camps, selecting staff, and planning activities; the use of camping as a training period; and ways in which the camp and home can work together.

An essay review . . .

DIAGNOSING FAMILY FUNCTIONING

NATHAN W. ACKERMAN, M.D.
Director of Professional Program, The Family Institute, New York

A FEW MONTHS ago a volume was published which offers a framework for a social casework approach to multiproblem families, based upon a specific research project. To judge the value of this work, "Family Casework Diagnosis," by Alice L. Voiland and Associates,* is no light task. Inevitably, a judgment of this sort is influenced by what one sees in the book, who sees it, and the position from which one does the seeing. This is controversial material on a highly controversial subject. Moreover, the present review must contain an element of special bias, since it is written by a psychiatrist and is influenced by his special interest in the psychodynamics and psychotherapy of the family group.

The aim of the study which this book reports was to find ways to improve diagnosis of the phenomenon of family disorder by designing a system of classification which would enable social caseworkers to deal more effectively with families burdened by dependency, illhealth, and maladjustment. It was one phase of an ongoing series of studies conducted under the auspices of Community Research Associates and was influenced at the start especially by a pilot study in 1952 which resulted in a classification of disorganized families according to 10 types of marital axes.

The method of investigation used was the rigorous analysis of a sampling of case material involving 888 families viewed as representative of the caseload of 50 agencies which report annually to the Family Service Association of America. Two basic types of data are presented: the statistical analysis of the characteristics of the 888 families; and a special study of a group of 100 of these families combining statistical analysis and casework interpretation.

The families had been carried in casework treatment from 4 to 18 months or longer. Of the 888 families, 87 percent had had more than five interviews: 62.7 percent of these interviews had been with husband and wife; 33.6 percent with wife only; 3.6 percent with husband only. Thus, these figures reflect not so much treatment of whole families as treatment of selected members of these families.

Social functioning and dysfunctioning of the families were evaluated in three areas: (1) child rearing; (2) marital functioning; (3) financial functioning.

Psychosocial disorders were classified in two categories, Level A and Level B. Level A consists of behavior that is prohibited by society or represents a failure to perform obligatory social duties in accordance with specific laws or rules, or conditions that require legal or official intervention. This category is exemplified in financial irregularities, antisocial acts, commitment of a family member to a mental institution, and family dissolution such as separation or divorce. Level B consists of behavior representing failure in types of social responsibility that do not fall into the category of Level A, such as severe maladjustment of parental functions or of child development, and distorted concepts of marital relationships. Of the group of 100 families studied, 50 percent showed Level A psychosocial disorders, 43 percent showed Level B psychosocial disorders.

From the findings, the authors suggest a classification of four disordered family types. They are: (1) the perfectionistic family; (2) the inadequate family; (3) the egocentric family; (4) the unsocial family. Beginning with the first category, the perfectionistic family, the authors assume that there is a serial progression from the milder to the more malignant patterns of disorder, culminating in the fourth and worst category, the unsocial family.

The perfectionistic family is described as one which places undue emphasis on being without fault and on avoiding open friction. The members believe that they do not measure up to the standards set for them by others or to those that are self-imposed. In this type of family, the parents emotionally overtax themselves and the children.

The inadequate family is characterized by increasingly poor resistance to the ordinary stresses of family living. It relies too readily upon others for encouragement, continued support, guidance, and help in resolving problems which the average family would be able to resolve for itself.

The egocentric family is characterized by the self-seeking intentions of its individual members. Its predominating characteristics are the self-centeredness, the overbearing manner, and the opinionated attitudes of the marital partners, which exacerbate problems of child rearing. While these characteristics may be held in different degrees by the male and female partners, the "aggregate effect" of the narcissistic needs of both parents establishes the family's distinctive emotional tone.

The unsocial family—the family which lacks social rapport with other people and with the environment—is viewed by the authors as the most malignantly disordered type. Its emotional climate and characteristic behavior are conditioned by the following tendencies present in both partners, and usually in the children: (1) a paucity of ideals in the resolution of ordinary problems; (2) deviant social conduct that constitutes a major or minor offense against the culture; (3) thought processes and powers of concentration so twisted that the individual endangers his own wel-

*Voiland, Alice L., and Associates: Family casework diagnosis. Columbia University Press, New York. 1962. 369 pp. $8.50.

fare or another's or becomes the victim of designing persons. More than one member is personally and socially maladjusted to a serious degree, either socially or legally. This handicaps the marital relationship, the parent-child relationship, work habits, child development, and the family's relationship with the community.

The authors of this work believe that the study they report contributes three new elements to the field of family casework: (1) the classification of systems of psychosocial disorder; (2) the classification of disordered family types in clinical terms; (3) a framework for family diagnosis suitable for analysis of psychosocial data about families.

Clearly, this report is an earnest effort, an ambitious and comprehensive attempt to shed further light on the problems and manifestations of family disorganization. The validity of the sampling procedure can be assumed, since this was carefully checked by expert consultants. There are, however, a number of questions which might be raised concerning conceptualization, method of data collection, and also the final interpretive conclusions.

Some Questions

In regard to conceptualization, the authors are confronted with the same difficulties that beset other investigators who set out to study family process. These difficulties derive from the need to delineate the links between individual functioning and family functioning, and to identify the nature of the exchange between the two which influences each in turn. The theoretical framework was influenced by and yet departed from the 1952 formulation of the 10 marital-axis types. In the text, one finds some apparent efforts to resolve contradictory sets of evidence. To illustrate:

> In so far as methodology was concerned, it appeared that the use of the 10 marital axes as the main points of focus for the analysis of family data had not yielded significant results. . . . There did not . . . seem to be any correlation between the nature of the marital emotional tie and the presence or absence of typical psychosocial pathology in other areas of adult behavior, such as child rearing, earning a living, or in the adjustment of children. . . . In other words, the fact that two spouses got along well together did not make the family invulnerable to other types of problems. . . . *There was clinical evidence, but inconclusive statistical evidence* (italics mine) that the character of the relationship between the two partners somehow related to the functional capacity of the total family.

The real issue is—how related?

The pilot study team of 1952 believed "that the soundest way, initially, to approach the problem of family classification was to proceed from the biological foundations of the family as represented in the male-female relationship of the marriage."

The classification of four disordered family types used in this study has, according to the authors, a "somewhat different base:" It derives from the aims of the marital partners as expressed in the marital relationship, child rearing, child development, and the financial functions of the family. What does the phrase, "somewhat different," actually mean? If the psychosocial functioning of the group can only be evaluated in relation to the family as a total living unit embracing all family functional areas, as the authors say their clinical evidence implies, then there seems to be a discrepancy between the type of information sought and the procedure used to obtain it.

This brings us logically to the second question, the method of data gathering. This procedure, based on interviews with individual members of the family rather than on direct observation of the whole family in action, does not seem congruent with the aims of the study—the achieving of a dynamic definition of the family unit.

The family is more than the sum of its parts. The attempt to arrive at a picture of the whole family by looking at separate individuals or only at the marital pair leads to an incomplete and inaccurate synthesis. A more suitable and more accurate method for obtaining and integrating observations relevant to a live picture of the functional family unit is the exploratory, therapeutically-oriented interview with the living family group—parents, children, and where indicated, grandparents or other significant relatives.

What Comes First?

The investigators were faced with a painful dilemma. At some levels there were contradictions between the clinical findings and the evidence presented by supposedly objective statistical analysis. Which should they rely upon?

At the present stage of development in the behavioral sciences, our knowledge is relatively crude. At the borders of tested knowledge investigators not infrequently are tossed into sharp conflict. If two methods of investigation present contradictory evidence, on which method shall they pin their faith?

Alice L. Voiland will respond to some of Dr. Ackerman's comments about the study described in her book, "Family Casework Diagnosis," in the July–August 1963 issue of CHILDREN.

In the special area of the relations of family dynamics to social health and mental health, it seems to me the first responsibility is to seek out the core concepts, to implement the clinical hunch in the design of an appropriate and valid conceptual framework. Until we achieve this, it will be difficult to know what to measure and how to measure. Statistical analysis, applied in advance of accurate and adequate conceptualization of the relevant dynamic phenomena, may bring only confusion.

However, when we look at the 13 main sections of the 42-page schedule for obtaining information for this study, we find a conceptual movement from parts of the family, either individual members or the marital pair, to the family as a dynamic unity. To obtain what is sought, is it not important to begin rather with the family as a dynamic functional unity?

Only in this way can one design a satisfactory theory of family dynamics and development which incorporates an appropriate theory of role adaptation and also a theory of personality. The design of such a conceptual framework would be facilitated by a procedure involving exploratory interviewing with the family as a functional whole. The idiosyncratic pattern of equilibrium of the multiple functions of the family group is the central property of the family phenomenon that should be illuminated in any theory of family behavior, both in illness and in health.

The troublesome questions the authors of this study faced in interpreting their data are of course the results of earlier problems in conceptualization and method of study. In the description of the four disordered family types, they refer again and again to the "aggregate effect." In other words, these

four diagnostic family types derive somewhat from the adding up of the character traits of the family members, especially the character traits of the two parents. This is not quite the same as a definitive characterization of the family as a functional unity reflecting in a unique way the homeostatic processes of the family group. One would be inclined to suspect that these characterizations of family types refer to component qualities of family functioning rather than providing a dynamic definition of the family entity as a living whole.

One might also raise the question as to whether these four types of families exist phenomenologically on the same level or on different levels. Compare, for example, the perfectionistic family and the unsocial family.

It is relevant, also, to consider to what extent the types of family functioning described are culturally bound. Are the adaptive patterns themselves the reflection of certain kinds of cultural and class belongingness? From the description offered of the perfectionistic family type, it would appear so; but the unsocial family type seems to relate to a conspicuous form of sociopathic family adaptation that takes the family out of the surrounding community culture.

In dealing critically with this study one must also consider the implications of its seemingly one-sided focus on the so-called multiproblem family. It is as if such families are the disorganized and sick ones while the other families in the community function in at least a tolerably satisfactory manner. But this of course is not true. The multiproblem family may represent the extremes of dysfunction, but the seeds of disorder in contemporary community life invade all types of families. This may be obvious, but it ought not to be either overlooked or minimized.

The study makes reference to an idealized normal family, but the model of such a family is not presented. There is a need for the development of a total theory of family dynamics out of which we may derive levels and degrees of deviance which would encompass multiproblem families, as well as families of other types.

The explicit consideration of these debatable questions is essential. The emergence in this study of some contradictions of evidence and the resulting complexities of interpretation simply affirm the sheer scientific enormity of the problem of family dynamics. This in no way detracts from the merit of this contribution to theories of social casework. Without doubt it will be widely read and discussed.

The author wrote this essay review after consultation with Frances Beatman, Sanford Sherman, and Celia Mitchell of the Jewish Family Service, New York.

BOOK NOTES

LESSONS FROM ANIMAL BEHAVIOR FOR THE CLINICIAN. S. A. Barnett, editor. Medical Advisory Committee of the National Spastics Society, 12 Park Crescent, London, W. 1, England. 1962. 51 pp. $2 or 12 shillings and sixpence.

This collection of six essays, by zoologists and behavioral scientists, focuses on the implications of research in animal behavior for an understanding of human development.

In the opening essay, S. A. Barnett of the University of Glasgow pinpoints areas that such animal research can enrich: human learning processes, the physiology of anxiety, and the distinction between stereotyped behavior common to a species and innate drives.

Some of the research findings stressed in the following essays are: that there is an optimal level of stimulation for each individual, and, up to a point, stimulation in early life produces a superior animal, who learns faster, is less emotional and more highly motivated and more resistant to stress, but stimulation beyond that point produces the opposite results; some stressful stimulation is needed in infancy if the endocrine response to noxious conditions is to develop best; and there is an optimal stage in each animal's life for development of each sort of behavior and the learning of each skill and inhibition.

WORK-STUDY PROGRAMS FOR ALIENATED YOUTH: a casebook. George W. Burchill. Science Research Associates, Chicago, Ill. 1962. 265 pp. $4.95.

Dave, the school dropout with a background of repeated failures, who graduated from a work-study program to a full-time job, and Fred, truant and gang leader at 16, who, during a work-study program, became convinced by his part-time employer to stay in school and try for a diploma, are among the 25 youths whose histories this book cites in a sampling of what is being done for young people in 9 work-study education programs.

The book describes programs conducted by eight public schools and one quasi-public institution for delinquent boys, all selected as outstanding by the Commission on the Role of the School in the Prevention of Juvenile Delinquency of the educational fraternity, Phi Delta Kappa.

A LETTER TO JIMMY. Henry Viscardi, Jr. Paul S. Eriksson, Inc., New York. 1962. 165 pp. $3.50.

"The trick is to reach out and be a part of the world now," explains this book-length letter to a disabled youth, a blend of peptalk and a briefing on how to carve out a full and rich life for himself. This is done, says the author—who, though born without legs, founded and now heads a firm hiring over 400 disabled—mainly by making one's abilities, not disabilities, count.

Writing for disabled youth everywhere, the author discusses questions of career, school, marriage, and sports, frequently illustrated by real life situations encountered by disabled young people he has known.

HERE AND THERE

Day Care for Children

A review of day-care activities within the States indicates that the State welfare departments have been getting ready to take advantage of earmarked funds for day-care services should these be made available by Congress as authorized in the 1962 amendments to the Social Security Act. Among the requirements for qualifying for such funds after fiscal 1963 are:

• *The existence of a State advisory committee on day care.* In 31 States, statewide advisory committees on day care either have been established or are in the process of being established. Activities of these committees vary according to the level of development of day-care services in the State. Improvement of standards of day care appears to be the task most of the committees tackle first, a survey of needs in the State comes second. The committee will also advise the States on such problems as employment of staff, setting fee scales for parents to pay according to ability, and planning for training personnel.

For example, in Maryland the day-care commission plans to assess available facilities for children and their adequacy in quality, quantity, and distribution; to improve standards; to review the licensing accreditation system; to make recommendations on the establishment and coordination of services, the sources from which funds may be obtained, the appropriate State agency to be given responsibility for carrying out the day-care services program, and needed legislation. The commission has been holding public hearings in various parts of the State to determine what communities are doing and what needs to be done; has arranged with the State's departments of health, education, and welfare to send a questionnaire to their respective local affiliates to assess day-care activities; has employed a research specialist to develop a prospectus for action after all the information is gathered and coordinated; and has planned for a State conference on day care to be held in Baltimore on October 31.

• *Provisions for licensing day-care facilities.* Two States, Massachusetts and Wyoming, passed licensing laws within the past year and similar measures are pending in a number of other States. Altogether 51 States and other jurisdictions either have licensing authority for day care or have licensing bills pending in their State legislatures.

• *Cooperative arrangements among the State welfare, health, and education departments.* In 36 States the health, education, and welfare departments work together on some aspects of day care, most often through representation on committees to develop or improve standards. In a few States the three departments give consultation to each other. In several States the health department provides inspection in facilities licensed by the welfare department. In at least one State there is a written cooperative arrangement.

• *The employment of day-care staff by the State welfare department.* Fourteen States now have such staff.

Most of the 36 States which now include provision for day-care services in their child welfare services plans, using Federal child welfare services grant-in-aid funds for the purpose, have indicated that if earmarked funds for day care become available, they will expand these provisions. The plans for expansion include establishment of family day-care programs; the opening of day-care centers under public auspices; the purchase of care for children in established licensed facilities; the development of intensive training courses for day-care personnel; the provision of day-care services to children of agricultural migrants; and the employment of licensing and consultation staff.

Problems which seem to be faced in many States are: (1) lack of trained personnel equipped to carry day-care responsibility; (2) pressure to utilize day care to get families off the public assistance rolls without consideration of the best plan for the child and the family; (3) lack of adequate facilities in which to place children; (4) lack of services for infants and school-age children.

Increased interest in developing research and demonstration projects in the field of day-care services is evident from the many requests received by the Children's Bureau for research and demonstration funds. Among the recent grants which have been made is one to the University of Illinois School of Social Work for training nonprofessional persons for licensing independent family day-care homes and independent foster homes.

—GERTRUDE HOFFMAN

Research and Demonstration

By early April of this year, 11 international research projects in maternal and child health and social welfare, to be supported by U.S. counterpart funds, had been approved. The projects are to be undertaken in Israel, Pakistan, and India.

Sponsored by the Welfare Administration and the Children's Bureau, U.S. Department of Health, Education, and Welfare, the projects were made possible by provisions of the Agricultural Trade Development and Assistance Act of 1954, as amended. Under this act foreign currencies accepted by the United States for the payment of surplus agricultural commodities can be used for studies of value to the United States and to the country conducting the research. Appropriations of such funds to the Welfare Administration made by Congress for 1962 for cooperative research in social welfare and maternal and child health make possible the development of research projects in these fields in Poland, the United Arab Republic, Yugoslavia, and Burma, as well as in the three countries with ongoing projects.

Projects underway in Israel include a longitudinal study of growth and development of children from various social strata and ethnic groups in that country, and studies of the socioethnological factors in the etiology of toxemia in pregnancy, the institutionalization of children, the forces acting in street-corner groups, and social services from the user's viewpoint.

Two projects are underway in Pakistan—a survey of diarrheal diseases among children in that country, and a study of the effectiveness of social work training at Punjab University in

relation to the social welfare needs of Pakistan. In India a study of the role of a community development program will appraise factors influencing the acceptance and rejection of innovations by the villagers.

India and Israel have submitted a number of additional projects for review. Projects are also being planned in the United Arab Republic, Poland, and Yugoslavia.

. . .

Ways to improve the lot of children whose mothers are hospitalized for mental illness are being sought in a demonstration project of the Department of Maternal and Child Health of the Harvard School of Public Health, preliminary findings of which were released last fall. Centered in one of Massachusetts' State mental hospitals, at Medfield, which serves patients from 15 communities, the study is designed specifically to improve casefinding of children needing help when the parent is admitted or about to be admitted to the hospital; to develop ways of assessing family needs, strengths, and resources for remaining intact, and methods of assessing the need to strengthen community agencies' help to them; and to evaluate the effectiveness of the relationships between the families and community agencies. Other goals are to determine whether community services can be organized to provide supportive and comprehensive care for children of families with repeated hospitalizations; and to analyze family difficulties in the care of such children and family experiences during crises of mental illness and hospitalization.

The project is in followup of a 1958–60 pilot study of children of parents hospitalized for mental illness to determine what arrangements had been made for their care. (See CHILDREN, May–June 1959, p. 114.) The current project is underway in three communities: Newton, Quincy, and Needham, with community leadership in the project assigned to a single agency in each community.

At the hospital, a project staff member assesses the family situation of selected patients with children, visits the child's caretaker at the family home, and refers the family to the community agency for service if needed. A control group will be studied without referral for service.

A preliminary analysis reported on at the annual meeting of the American Public Health Association last fall revealed that the project has brought about fuller history taking on admission to the hospital, which formerly had asked for little or no information on the patients' children; and has led to the assumption by the hospital social worker of the liaison function with community agencies and to her participation in community planning for the patients and their families. The investigators point to the need for overcoming families' resistance to community help and the need for agencies to modify their relatively greater emphasis on long-term casework directed to the more chronic disorders of spouse or children rather than on services directed to the acute problem.

. . .

The National Institute of Child Health and Human Development, authorized by Congress in 1962 (CHILDREN, November–December 1962, p. 242), was established by the Public Health Service on February 4 of this year. The new Institute's functions—research into the health status, needs, and problems of human beings in various stages of development—are organized around two research centers formerly in the Division of General Medical Sciences of the National Institutes of Health: the Center for Research in Child Health, and the Center for Aging Research. Director of the Institute is Dr. Robert A. Aldrich, formerly chairman of the pediatrics department of the University of Washington School of Medicine.

Dependent Children

The great majority of jobless fathers on the rolls of the Federal-State program of aid to families with dependent children are school dropouts, many of whom are equipped only for unskilled labor, according to preliminary findings of a survey of recipients, conducted by the Bureau of Family Services, Welfare Administration, and released in February of this year. At the time of the study, in late 1961, only 9 percent were found to have finished high school, compared with the 40 percent of men in this country who are high school graduates. Only 3 percent had been white collar workers, as against almost 35 percent in this category among the Nation's employed males. About 3 percent had never held a full-time job.

No father was present in almost 78 percent of the AFDC homes. The father was present but incapacitated in about 15 percent of the cases, and was at home but unemployed in 5 percent. In 2 percent of the cases, the need for assistance was caused by the mother's absence, disability, or unemployment.

The median age of the unemployed fathers in the AFDC program was 34.7 years, almost 4 years below the median for all heads of husband-wife families with children under 18 in the Nation. Nearly one-third of them were under 30; only 20 percent were 45 or older.

Child Welfare

The Field Foundation recently granted $55,000 to the Child Welfare League of America for a 3-year project to promote the use of uniform cost accounting procedures among institutions caring for children in the Nation. The project is being administered jointly by the League and the Children's Bureau, which together mapped out its design. This focuses on encouraging the use of the "Manual for Cost Analysis in Institutions for Children" published in the summer of 1962 by the League.

A coordinator, employed by the project, will promote the training of research, statistical, or accounting personnel on the staffs of State departments of public welfare, united community funds, federations of social agencies, and other organizations in the cost accounting procedures prescribed by the manual. These persons will in turn train and supervise staffs of local public and voluntary institutions in the procedures.

The manual was developed by the League and the California State Department of Social Welfare with the use of Federal child welfare services funds in response to a need, made especially apparent in purchase of care arrangements between public agencies and voluntary institutions, for more standardized procedures in determining costs of institutional care.

. . .

A new voluntary agency, the National Council on Homemaker Services, was incorporated in January 1963, thus bringing to fruition a recommendation of the 1959 National Conference on Homemaker Services for the creation of a continuing national mechanism for studying homemaker programs and

helping communities to develop them. (See "A New Look in Homemaker Services," by Maud Morlock, CHILDREN, May–June 1959, p. 112.) In February, the National Committee on Homemaker Service, which had a major role in the promotion of the new agency, voted to disband and to transfer its assets to the Council. Other organizations active in the creation of the Council were the National Social Welfare Assembly and the National Health Council.

The new agency's board, composed of community leaders from various parts of the country under the chairmanship of Mrs. Juan Trippe of New York City, has set its first task as the raising of funds for agency operations, including the employment of staff. The Council's headquarters are in New York City.

Services in Housing

The Elm Haven Housing Project in New Haven, Conn., was selected early this year as the site of a demonstration project of concerted services for families in low-rent housing. (See CHILDREN, November–December 1962, p. 242.) This is the second project spearheaded by the Task Force on Health, Education, and Welfare Services and Housing in a coordinated effort of the U.S. Department of Health, Education, and Welfare, the Housing and Home Finance Agency, and State and local agencies to lift the health, social, and economic status of residents in public housing developments.

The characteristics and needs of families in the 855-unit housing project in New Haven are under study by a committee of Community Progress, Inc., on which are representatives of State and local agencies concerned with the project's services. Subcommittees have been set up to focus on education and employment; health; school readiness; family welfare; residents' participation; and youth and recreation.

A grant of $82,529 per year for 5 years was recently awarded by the Federal Vocational Rehabilitation Administration to the Missouri State Department of Vocational Rehabilitation to set up a special vocational rehabilitation unit in the Pruitt-Igoe Housing Development of St. Louis, site of the first concerted services project launched last summer. The new unit will provide rehabilitative services for mentally and physically disabled residents. These services are expected to include medical help, hospitalization, artificial limbs, and psychological and psychiatric care.

Staff Development

Financed by a grant of $104,925 from the Field Foundation, an institute to train staff development people in social work in State and local public welfare agencies was launched during early February in Washington, D.C., by the American Public Welfare Association and the Council on Social Work Education of New York with the cooperation of the Children's Bureau and the Bureau of Family Services, U.S. Department of Health, Education, and Welfare. Alice Taylor Davis of the Howard University School of Social Work is project director. About 100 participants, more than half of all those employed in full-time training of public welfare staff, attended the 2-week session, after which they returned for 3 months' practice on the job before reconvening for the final week of followup study.

The institute is designed to demonstrate an orderly method for organizing and presenting content in this area and help develop teaching skills and methods. Its purpose is to help State public welfare directors meet a regulation of the Department of Health, Education, and Welfare requiring that they have in operation by 1967 an effective, organized staff development program. (See CHILDREN, January–February 1962, p. 36.)

Manpower studies have shown that only 5 percent of public assistance staff and 25 percent of public child welfare staff are professionally trained. (See CHILDREN, July–August 1961, p. 154.)

Vaccines and Drugs

Licenses for the commercial output of two types of measles vaccines were issued March 21, by the Department of Health, Education, and Welfare, on the recommendation of the Public Health Service. Nearly 50,000 children in the United States received these vaccines in field trials, about 25,000 having been given the live vaccine, either alone or in combination with gamma globulin. (See CHILDREN, January–February 1962, p. 34.)

Simultaneously with the licensing action, the Ad Hoc Advisory Committee on Measles Control of the Public Health Service issued a statement to guide the Nation's physicians on the status of the measles vaccines and on their application. The statement indicates, among other things, that:

- The live vaccine induces active immunity after a single dose and produces, in the majority of those taking it, a mild or inapparent noncommunicable infection with minimal symptoms, but 30 to 40 percent have fever of 103° (rectal) or more. Strength and duration of antibody response resemble that of the natural disease. Standard Measles Immune Globulin given at the same time in the recommended manner sharply reduces clinical reactions.
- Antibody titers after three monthly doses of the inactivated vaccine are lower than those following the live vaccine and rapidly fall off. Duration of immunity beyond 6 months is unknown. This vaccine is preferred where the live vaccine is contraindicated: in the case of pregnancy, general malignancy, or egg sensitivity (since the vaccine is cultured in chick embryos).
- Live attenuated vaccine given 1 to 3 months after one or two doses of inactivated measles virus vaccine substantially lowers clinical reactions; the combination schedule of live and inactivated vaccines produces antibody titers higher than with the latter alone and apparently equal to those following live vaccine with gamma globulin.
- The vaccines are primarily for administration to children, ideally at 9 months or as soon thereafter as possible, and only for those without a history of measles. No protection is afforded by either vaccine after exposure to the natural disease.

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In a resolution adopted early this year, the executive board of the World Health Organization has asked the director general of WHO to facilitate ways of compiling information on serious adverse drug reactions and supplying this information to national health agencies. In the same resolution the board recommended that the World Health Assembly, convening this May, invite member States to seek agreement among members on the basic principles and minimum requirements applicable to the evaluation of drugs and to make available to WHO for rapid dissemination any action taken to prohibit use of a drug because of adverse reactions.

IN THE JOURNALS

Neglect and Abuse

The March 1963 issue of *Child Welfare* is focused almost entirely on the subject of neglect or abuse of children.

In one article six staff members of the Massachusetts Society for the Prevention of Cruelty to Children report on a study of abuse cases which found that the great majority of child abusers were the parents of the children, and that they tended to be young and to fall into three clusters of personality characteristics—hostile and aggressive; rigid, compulsive, and lacking in warmth; and passive and dependent. ("Physical Abuse of Children—An Agency Study.")

In other articles, a hospital social worker outlines problems of identifying neglecting parents and those among them who are likely to respond to treatment ("Who Insures the Child's Right to Health?" by Helen E. Boardman); and a casework supervisor in a public child welfare agency writes of the importance of an agency's experience and philosophy in helping the protective service caseworker deal with pressures emanating from his own conflicts, the community, and law-enforcement bodies. ("The Protective Service Caseworker: How Does He Survive Job Pressures?" by Dolores M. Schmidt.)

Other articles consider child neglect from a legal viewpoint, the team approach in protective service, aspects of the Child Welfare League of America's standards for child protective service, and ways of prevention.

Becoming an Individual

Extracting from clinical observations made in a study of the separation-individuation phase of development in normal children (age range: 6 to 10 months to 3 years), two psychiatrists writing in *The Psychoanalytic Quarterly* for January 1963 report that the mother may read the infant's cues correctly, misread them, or selectively neglect cues, according to her particular needs, and that the normal child has "an amazing capacity to adapt to the needs, emotions, and demands of the mother." ("Certain Aspects of the Separation-Individuation Phase," by Margaret S. Mahler, M.D., and Manuel Furer, M.D.)

Their material, gathered from observations of mother-child interaction in a large playroom and from interviews with the mothers, demonstrates, according to the authors, a large range of response in normal mothers to separation from their children—reactions ranging from near mourning, attempts to hurry independent functioning, subtle combinations of both, and "seesawing" between psychologically getting rid of the infant and clinging to him. Noting that the normal mother anticipates separation-individuation in her baby long before he is actually at this phase, the investigators conclude that the child's pattern of individuation stems in large part from the mother's attempts to adapt to the child's maturation and his own efforts to adapt to his mother's fantasies.

Growing Up Negro

Under the title "Growing Up Negro," the January issue of the bimonthly journal *American Child* is a special issue on the problems of Negro youth. Its four articles, each written by an executive of a youth-serving agency, analyze the adverse effects of present-day racial discrimination in employment, housing, and education on Negro youth, American society, and the Nation's economy, and the shortcomings of steps being taken to overcome the resulting problems; and make specific suggestions for achieving more rapid progress.

Foster Family Sessions

The value of adapting family session techniques to the supervision of children in foster family homes, by interviewing the child and the foster parents together, is discussed by two social caseworkers in *Social Casework* for March 1963. ("The Use of Family Sessions in Foster Home Care," by Dwaine R. Lindberg and Anne W. Wosmek.)

Maintaining that the traditional approach of seeing the foster mother alone unwittingly separates her from the family, they point out that family interviewing gives the caseworker an opportunity to observe directly the interaction between the foster family members and the foster child and minimizes the concern of foster parent and foster child over the caseworker's reactions to what has been reported about them by the other. They also assert that the family technique promotes broader understanding by the clients of the caseworker's role, and enhances communication between foster family and the child in relation to the conflict created by the child's divided loyalties between his own and his foster parents.

Handicapped Children

Some of the services that bring greater usefulness and independence to the Nation's 4 million handicapped children are discussed in a special section of 5 articles in the March–April issue of the *Rehabilitation Record*. ("Special Services for Handicapped Children.") The section provides a general look at the extent and type of both mental and physical disability among young people and discusses existing and prospective special education programs to meet their needs. Two programs that give special training to handicapped young people are described—one in the public schools of Champaign, Ill. ("A Bridge from High School to Work," by E. C. Cline and Merle B. Karnes), and the other in a residential school for handicapped children in Jamestown, N. Dak. ("The Case for the Residential School," by Anne H. Carlsen).

Human Dignity

In the January 1963 issue of the quarterly *Public Welfare*, Marvin E. Larson, director of the Kansas State Department of Social Welfare, writes of human dignity as "the most important single achievement of the human race" and "the basis of all morality." He warns of the danger of intrusions upon this concept when the "aristocracy of the capable" fails to understand the inequalities of birth, nurture, and opportunity behind the failure of some persons to achieve a strong sense of responsibility. ("The Aristocracy of the Capable.")

In the same issue, Dorothy J. Kie-

ster, consultant on community services to the North Carolina State Board of Public Welfare, stresses the importance of *caring* in efforts of public welfare workers to mobilize community resources to meet the needs of children. She names as essential to such efforts the ability to see the individuals in a caseload, knowledge of the resources and ability to work with the people who control them, a willingness to share, and investment in training. ("Mobilizing Community Resources to Meet the Needs of Children.")

Impaired Speech

In *School Life* for March 1963, Nancy E. Wood of the Office of Education reviews the speech impairments most frequently encountered in the classroom—in phonation, fluency, articulation, and language—supplying clues for identification by the teacher. ("Identifying Speech Disorders in the Classroom.") Noting that most of the disorders are associated with voice strain or misuse, she advises teachers to refer the child with a deviant voice quality for laryngeal examination before scheduling him for help in school and to provide group therapy or other indirect treatment for the child with defective articulation.

MOVING AHEAD AGAINST MENTAL RETARDATION

HOW TO MOVE ahead to carry out the recommendations of the President's Panel on Mental Retardation was the subject of an all-day conference held in Arlington, Va., on April 9, as the swan song of the Citizens' Committee for the 50th Anniversary of the Children's Bureau, which sponsored the Bureau's stock-taking birthday party on the same date a year ago. (See CHILDREN, May–June 1962, page 120.)

The 75 conferees included members of the Citizens' Committee, representatives of the President's Panel on Mental Retardation and its Task Forces and of the Children's Bureau staff, and specialists from the fields of pediatrics, obstetrics, and other fields concerned with the mentally retarded. Their point of departure was the panel's report, "A Proposed Program for National Action to Combat Mental Retardation," which was submitted to the President last October (see CHILDREN, January–February 1962, page 29). Featured speakers at the general sessions included: Secretary of Health, Education, and Welfare, Anthony J. Celebrezze; Leonard W. Mayo, chairman of the President's Panel; Mrs. Sargent Shriver, consultant to the panel; Edward Davens, deputy commissioner of health for the State of Maryland; Donald Stedman, associate director of research for the Joseph P. Kennedy, Jr., Foundation; and Gunnar Dybwad, executive director of the National Association for Retarded Children.

A considerable part of the speeches as well as of the deliberations in afternoon group discussions was devoted to the possibilities of pending congressional legislation for stimulating State and local action, both of a public and voluntary nature, to prevent retardation as well as to provide better services to the retarded. Prevention, it was generally agreed, necessarily involves activities beneficial to the entire population, such as research into fetal and neurological development to identify the points where damage occurs, efforts to improve and extend prenatal and postnatal care, and the provision of nursery schools and kindergartens to provide intellectual stimulation to children early in life.

Consideration of where to start in the development of a comprehensive program of prevention led to an apparent consensus that this must be with "high risk groups"—the women of low socioeconomic status who are not getting adequate prenatal care and the "culturally deprived" children of the same socioeconomic background. One conferee, however, remarked that in the slum cores of some large cities such "high risk groups" would consist of all the women and children in the area.

The conferees put considerable stress on educational efforts—to help the unmotivated, high risk groups appreciate the importance of preventive services, to help the retarded themselves to develop their capacities, and to help physicians, social workers, teachers, and the general public achieve a better understanding of the needs of the retarded and their families. Stress was also put on the importance of expanding professional education to help meet the manpower needs of an expanded program, and of training volunteers and middle-level auxiliary personnel to supplement the efforts of the highly skilled in the provision of services.

Concern about how to reach the "unmotivated" with appropriate services—especially prenatal care—focused largely on the way services are provided and the attitudes of the servers, with emphasis on the need for greater consideration of the dignity of the client as a human being. The enhancement of human dignity was, in fact, identified as the chief reason for providing special and basic services to the mentally retarded and for the President's proposals to Congress on February 5 this year that Federal funds be provided for the establishment of 10 research centers concerned with mental retardation and grants to the States for the construction of facilities for the retarded and for the development of comprehensive plans of action in relation to mental retardation.

"While all people are not born equal," said Melvin A. Glasser, chairman of the Citizens' Committee, "the very definition of democracy demands that they have equal access to opportunities for development."

—KATHRYN CLOSE

READERS' EXCHANGE

BERNSTEIN: ***A stimulus to reappraisal***

Rose Bernstein, in her article, "Gaps in Services to Unmarried Mothers" (CHILDREN, March–April 1963), has given us some words which should make us do some critical thinking about unmarried mothers, about ourselves as members of the helping professions, and about our services and their utilization as well as the lack of services.

It is not enough to provide services to unmarried expectant mothers and then wait for them to take the initiative in seeking help. We must develop and use sound techniques to encourage persons in need to use these services. In some instances, we may have to take the first step not only toward the unmarried expectant mother but also toward the unmarried father and the families of both if we really want to do anything about gaps in services.

It is easy to think only of the gaps in other community services without facing the gaps within one's own agency. Many of us have built into our agency programs mechanisms for continuing review of policy and practice. Let's take another look. For example, take several statements in the Bernstein article relating to maternity homes:

- That many maternity homes tend to give priority to mothers who plan to relinquish their babies.
- That some maternity homes frankly or indirectly discriminate against Negroes in their admission policies.
- That maternity homes, which serve only 10 percent of the unmarried mother population, are taking on the character of small psychiatric centers, thus raising the question of whether a proliferation of services for a small segment of a client population is the most effective allocation of community resources.
- That attempts to keep unmarried mothers in followup treatment are not significantly successful.

This may be the time to rethink the purpose and goals of the maternity home as community agency not only in relation to these statements, but also in relation to changing times. For example, is there any justification for offering service on the basis of whether plans are to keep or relinquish the baby? I have heard some social workers say that we may have to encourage the unmarried expectant mother to keep her child because of the reported decline in available adoptive homes. What is the rationale for helping the unmarried mother to surrender her child in a time when there is an oversupply of adoptive homes and helping her to keep the child when we anticipate a shortage of adoptive homes?

In addition to our responsibility for agency self-examination, we have a responsibility in relation to gaps in other community services. Mrs. Bernstein refers to the 1962 amendments to the Social Security Act as a forward step in developing services to unmarried mothers. We have a responsibility to contribute to State implementation of these amendments. The National Social Welfare Assembly, 345 East 46th Street, New York, has developed a checklist of questions on State public welfare legislation. You can get it for 15 cents if you want to do something about closing the gaps in service.

Jane E. Wrieden
Colonel, The Salvation Army

PANNOR: ***Unmarried fathers***

At the recent annual meeting of the American Orthopsychiatric Association in Washington, D.C., many people stopped at the booth of the National Association on Service to Unmarried Parents to express approval of the title of the organization—"Unmarried Parents," instead of "Unmarried Mothers." I am pleased to see that the Children's Bureau also carries out this idea in the March–April issue of CHILDREN, with the overall title "Unmarried Parents." I would like to comment on one of its articles, "Casework Services for Unmarried Fathers." The author, Reuben Pannor, and his agency deserve our highest praise for what they are doing. Over a period of years they have given consistent service to the boys and men, fathers of the children born out of wedlock, for whom the agency has assumed some responsibility.

The "Child Welfare League of America Standards for Services to Unmarried Parents" also emphasizes the importance of work with the father as follows: "The unmarried father, especially the adolescent, should have an opportunity for casework help. Social agencies . . . should *reach out* to the father more than they have in the past. . . . Special efforts should be made to work with him, and to develop studies regarding him. . . . In providing casework help to the unmarried father, it is important to regard him as an individual with his own needs and problems, rather than as an adjunct to the plan for the unmarried mother and child, or only as a source of financial support."

The public at large, the legal and medical professions, social and health agencies, and our schools, in one way or another, are concerned with this trio of mother, father, and baby. But the attitude expressed toward the father may be vastly different from that toward the mother. Social agencies, by and large, have only slight knowledge of the father—usually what the girl chooses to tell them. Rarely, is there direct contact with him. Mr. Pannor suggests some of the reasons why. This boils down to the lack of conviction of the importance of the man in the total situation.

One hears much concern expressed, and rightly, over pregnancies in our schools, and the tragedies that often occur to both the boys and girls. Not a panacea, but one development that might help would be for a concerted effort to get more social workers in our schools. Hopefully they could see signs of danger and perhaps lend a hand before it is too late.

The problem of young unmarried parents is part of the wider problem we face—how to help young people grow strong enough to make wise choices and fulfill their potentials as responsible human beings.

Maud Morlock
Former Consultant on Services to Unmarried Parents, Children's Bureau

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Frontispiece, Esther Bubley for the Children's Bureau.
Page 107, Association for the Help of Retarded Children, New York City Chapter.

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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CHILD WELFARE STATISTICS, 1961. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 66. 1962. 84 pp. Single copies available from the Bureau without charge.

This compilation of data on child welfare programs during 1961 presents through 122 statistical tables information on: expenditures for public child welfare services; personnel in public child welfare agencies and those granted educational leave; children for whom adoption petitions were granted; and children receiving services of various types.

ORGANIZATION FOR CHILD WELFARE SERVICES; a statement on State-administered and State-supervised child welfare programs. Hannah M. Adams. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 14 pp. Single copies available from the Bureau without charge.

Discusses criteria for determining the administrative responsibility for public child welfare programs which result in the following classification: local administration, 11 States; local administration, with regular exceptions, 9 States; mixed State and local administration, 3 States; State administration, with a few exceptions, 4 States; State administration, 26 States.

DESIGN FOR COMMUNITY ACTION; how to mobilize community resources to help youth enter the world of work. Department of Labor, Bureau of Labor Standards. Bulletin 248. 1962. 36 pp. 20 cents.

Part 1 discusses the employment problems of specific groups of young people—school dropouts, young people of minority groups, rural youth and those in agricultural migrant families, young people with physical and mental handicaps, and high school graduates with no vocational training—in relation to the changing requirements of the current job market.

Part 2, emphasizing community action, describes various youth service and training programs which have been organized by communities; suggests ideas to aid other concerned communities in planning, launching, and continuing a program to help young people achieve their work potential; and discusses the responsibility of Federal, State, and local agencies, national voluntary organizations, representatives of labor and management, educators, and others in promoting youth training and employment programs.

A PROPOSED PROGRAM FOR NATIONAL ACTION TO COMBAT MENTAL RETARDATION; a report to the President. October 1962. The President's Panel on Mental Retardation, Department of Health, Education, and Welfare. 1963. 201 pp. 65 cents (paper cover).

This report was reviewed in some detail in the January–February 1963 issue of CHILDREN. (pp. 29–31.)

YOUR BABY'S FIRST YEAR. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 400. 1962. 30 pp. 15 cents.

Designed for parents with low reading levels, this illustrated booklet explains the important points in baby care.

SELECTED FILMS ON CHILD LIFE. Inez C. Lohr. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 376 revised. 1962. 99 pp. 35 cents.

Superseding the 1959 edition, this catalog lists 400 films.

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